THE APPLICATION OF HEALTH PSYCHOLOGY PRINCIPLES TO WORKING WITHIN A STOP SMOKING SERVICE BASED IN A DEPRIVED INNER CITY AREA

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SECTION A

PREFACE

PREFACE

Smoking is an extremely complex health behaviour which involves a combination of biological, psychological and social processes (Marks, Murray, Evans & Willig, 2000). Smoking as an addiction and the process of cessation is an important area for health psychological practice and research. This thesis focuses on the application of health psychology principles while working as a Health Psychologist in Training in an inner-city Stop Smoking Service, located in a deprived area.

The provision of high quality Stop Smoking Services is a top priority for the government in reducing health inequalities and improving health among local populations (Department of Health, 2011). Evidence-based stop smoking support is also considered to be highly effective both in cost and clinical terms (Department of Health, 2011). The Stop Smoking Service, which provides the basis for this thesis, is located within the 19th most deprived borough in the country, which has a lower life expectancy than the national average ([redacted] PCT, 2006). There are extremes of wealth and poverty in the borough with some very affluent areas but in the most deprived areas there are i) lower life expectancies ii) higher standardised mortality ratios (SMRs) for premature death from all causes and iii) lower levels of perceived good health ([redacted] PCT, 2006). Through the research, professional practice and systematic review components of this thesis, the application of health psychology principles to working within a Stop Smoking Service, located in a deprived borough, is demonstrated.

Firstly, the research component of the thesis, explores smoking addiction from the perspective of young people from different ethnic backgrounds. The research examines the process of smoking from pre-initiation to cessation for adolescent Somali, Bangladeshi and White British smokers. The Somali and Bangladeshi community make up the largest ethnic

minority population within the borough (Office for National Statistics, 2001; Khan & Jones, 2002). On a national scale, the Somali and Bangladeshi communities make up some of the most deprived communities in the UK (Modood et al., 1997; Tinsley& Jacobs, 2006). There are high smoking rates among Bangladeshi and Somali adult males and reports of increasing rates for females, which is a disturbing trend. Yet youth smoking in these populations is very under-researched in the UK. Individuals from these groups are also less likely to access cessation services than the general population and hence are classified as 'hard-to-reach' by local National Health Service (NHS) services. Therefore the study was conducted in an effort to help address health inequalities, and also from a critical health psychology perspective, it can be argued that it is important to acknowledge wider socio-economic determinants of health. The study highlights the similarities and differences in the experience of smoking between the different ethnic groups and also presents some of the challenges of conducting research with traditionally hard-to-reach groups. The findings could be used by Youth Services and Stop Smoking Services working with individuals from these ethnic groups.

Next, the professional practice component of the thesis firstly includes the generic professional competency. This provides discussion on how professional conduct was maintained while working at the Stop Smoking Service, which involved working in line with the British Psychological Society Code of Ethics and Conduct (2006), the Health Professions Council's Standards of Proficiency (2010) and also in accordance with a variety of NHS policies and guidelines. This impacted in all areas of practice, for example, the provision of stop smoking support to clients, the provision of smoking cessation teaching and training sessions to health professionals and community groups, and general day-to-day working. The case study also focuses on maintaining continual professional development as a Health Psychologist in Training, which involved attending health psychology conferences and having monthly health clinical supervision with the Manager, who was a Health Psychologist.

Finally, it involves providing psychological guidance and feedback to others, such as to Health Trainers and health psychology work experience students working at the service.

The professional practice component of the thesis also includes the teaching and training competency. This comprises of two case studies which reflect the experience of providing teaching and training in smoking cessation to two very different audiences. The first case study, which was filmed as part of the assessment procedure, involves providing level II stop smoking training (consisting of one-to-one behavioural support and the use of pharmacological aids) to health professionals. This consisted of imparting knowledge on theories of health behaviour change and developing skills involving the use of motivational interviewing techniques, to assist clients with smoking cessation. The second case study focuses on running a workshop on smoking cessation to young people with behavioural difficulties, at a youth accommodation unit. This involved relaying the process of smoking addiction and ways to assist with the cessation. Having to tailor the teaching and training methods accordingly to the different audiences helped to develop experience of designing training programmes. Also regularly delivering training programmes helped to build confidence in this competency.

Next, the professional practice component of the thesis comprises of the consultancy case study. This focuses on assisting a client with a 'stop smoking for Ramadan' health promotion campaign. The client was based at the Health Promotion Department of the Stop Smoking Service. The aim was to promote the harmful effects of smoking to the Muslim population in the borough during the Muslim holy month of Ramadan and to increase referrals to the Stop Smoking Service from adult Bangladeshi men. The campaign was an initiative employed by the Primary Care Trust (PCT) to address health inequalities in the area. The model adopted for the consultancy was the process consultation approach (Schein, 1999). The case study highlighted the process of conducting a consultancy project from the

planning stages through to the closing of the project, along with the challenges that were encountered.

Next, the first optional competency for the professional practice component of the thesis consists of delivering an intervention to change a health-related behaviour. This focuses on the clinical work carried out at the Stop Smoking Service, which includes the provision of stop smoking support in a group setting. Stop smoking support is provided to a range of clients including those with mental health problems, pregnant women and younger people. The case study focused on the implementation of a rolling group at the Stop Smoking Service and on the experience of one client called 'Bob'. The theoretical basis of the intervention, along with the range of clinical skills employed, was discussed. Also the challenges that were encountered in conducting a rolling format stop smoking group were described.

The second optional competency for the professional practice component of the thesis consists of directing the implementation of an intervention. This involves providing clinical supervision to two Health Trainers employed within the PCT. The Health Trainer initiative was implemented by the PCT as another way to help address health inequalities and to encourage hard-to-reach groups access healthcare services. Their role is to assist individuals with increasing physical activity, eating healthier and to stop smoking by using interventions based on health psychology principles. Providing clinical supervision to the Health Trainers involved providing managerial, educative and pastoral support. Also providing effective supervision required reflecting on supervision style and developing an effective supervisory relationship, which was discussed in the case study.

Finally, the systematic review component of the thesis focuses on exploring the effectiveness of community interventions in preventing young people from smoking. Community interventions take greater consideration of the importance of social influences on

smoking in addition to individual factors, which is in-keeping with many health psychology models of behaviour change that recognise the importance of social factors. Also the area of youth smoking is important because it is recognised that if smoking is prevented during adolescence, it is unlikely to occur after that (United States Department of Health and Human Services, 1994). The case study outlines the rationale for the review along with description of the process and discussion of results.

Overall each of the case studies highlights how a wide range of health psychology principles were applied in a variety of different contexts, while working within a Stop Smoking Service located in a deprived borough.

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SECTION B

RESEARCH COMPETENCE

Exploring the process of smoking pre-initiation, initiation, maintenance and cessation for adolescent Somali, Bangladeshi and White British Smokers

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ABSTRACT

A qualitative study was conducted to explore the process of smoking pre-initiation, initiation, maintenance and cessation for 16-17 year old, second generation Somali, Bangladeshi and White British, male and female smokers. The participants were all regular smokers (which was classified as smoking at least one cigarette a week) and were recruited from a deprived inner city borough via opportunistic and snowball sampling. Six focus group interviews were conducted with 5-6 participants in each focus group. The groups were split according to ethnic background and gender and the interviews lasted for approximately an hour. The data was analysed using grounded theory. Three core categories were identified for the different stages of the smoking process; 'construction of smoking fantasy' was representative of the pre-initiation state, 'construction of smoking reality' for the initiation stage and 'negotiating smoking reality' for the maintenance stage. The experience of cessation was encompassed in the maintenance stage. The over-arching core category for all three stages was 'negotiating smoking fantasy and reality'. Overall the experience of smoking was similar in many ways between the different groups but there were also distinctions. These distinctions centred around the greater influence of socio-cultural factors, such as religion, on the Somali and Bangladeshi participants and the influence of traditional smoking gender norms on the experience of Somali females and Bangladeshi females. The importance of conducting research with hard-to-reach groups, and the applicability of findings for healthcare services working with the Somali and Bangladeshi population, was discussed.

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CHAPTER 1

INTRODUCTION

1.1. Smoking as a public health issue

Smoking continues to be an important public health issue for the government in the United Kingdom (UK). It remains the most common cause of preventable disease and premature death in England with over eighty thousand deaths a year resulting from smoking (Department of Health, 2010) and is the primary reason for life expectancy health inequalities between the richest and poorest in society. Among men it is responsible for more than half the difference in the risk of premature death between the social classes (Jarvis & Wardle, 1999). Eight and a half million people still currently smoke in England (Department of Health, 2010) and with recent estimates that smoking costs the National Health Service (NHS) £5 billion a year (Allender, Balakrishnan, Scarborough, Webster & Rayner, 2009), which is more than three times the previous estimate, it is clear that smoking still poses a considerable health and financial burden on society.

1.2. The importance of targeting youth smoking

The majority of smokers start smoking during adolescence, with around two- thirds commencing smoking before the age of 18 years (Office for National Statistics, 2008). Also as young smokers tend to continue their habit into adulthood (Charlton, Moyer, Gupta & Hill, 2010) the prevention of initiation of smoking in young people continues to be a major goal for tobacco control.

Exploring the Process of Smoking

The effects of smoking at a young age include addiction and immediate and longer-term health risks. The World Health Organisation's International Classification of Diseases [ICD-10] (2007), cites addiction as a dependence syndrome, consisting of:

> a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.
>
> World Health Organisation (2007)

With regards to addiction, research has shown that children who smoke become addicted to nicotine very quickly. 11-16 year olds show signs of addiction within four weeks of starting to smoke (DiFranza et al., 2000). A study by Fidler, Wardle, Henning-Brodersen, Jarvis and West (2006) found that even smoking a single cigarette can be a risk factor for becoming a regular smoker up to three years later. This suggests that there is a sleeper effect with a period of dormant vulnerability for the young person. Once a young person becomes a regular smoking then dependency has been found to increase. A recent survey on school pupils found that although almost two thirds (64%) of young regular smokers had tried to give up smoking, more than two thirds (69%) would find it difficult not to smoke for a week and three quarters (76%) would find it difficult to stop altogether (The NHS Information Centre, 2009). It was also found that the longer the period of regular smoking and the heavier the smoker the more dependent on smoking the pupils felt (88% of pupils smoking regularly for over a year would find it difficult to stop smoking compared with 62% of pupils smoking regularly for less than a year and 99% of heavy smokers [more than seventy cigarettes a week] would find it difficult to stop smoking altogether compared with 56% of light smokers [fewer than twenty one cigarettes a week]).

The negative effects of smoking on young peoples' health can be immediate, for example, young people who smoke are two to six times more susceptible than their non-

smoking peers to respiratory problems such as, coughing, wheezing and phlegm production (United States [US] Department of Health and Human Services, 2004). Smoking can also exacerbate asthma symptoms in those who already have the condition and can increase the chances of developing it in those young people with no prior history (US Department of Health and Human Services, 2004; British Medical Association [BMA], 2002; Gillard et al., 2006). It can also result in impaired lung growth in children and young adults (US Department of Health and Human Services, 2004) and general reduced immunity (Holt, 1987). As a result children who smoke are more often absent from school (While, Kelly, Huang & Charlton, 1997) and generally less fit than their non-smoking peers (Marti, Abelin, Minder & Vader, 1988; Klausen, Andersen & Nandrup, 1983).

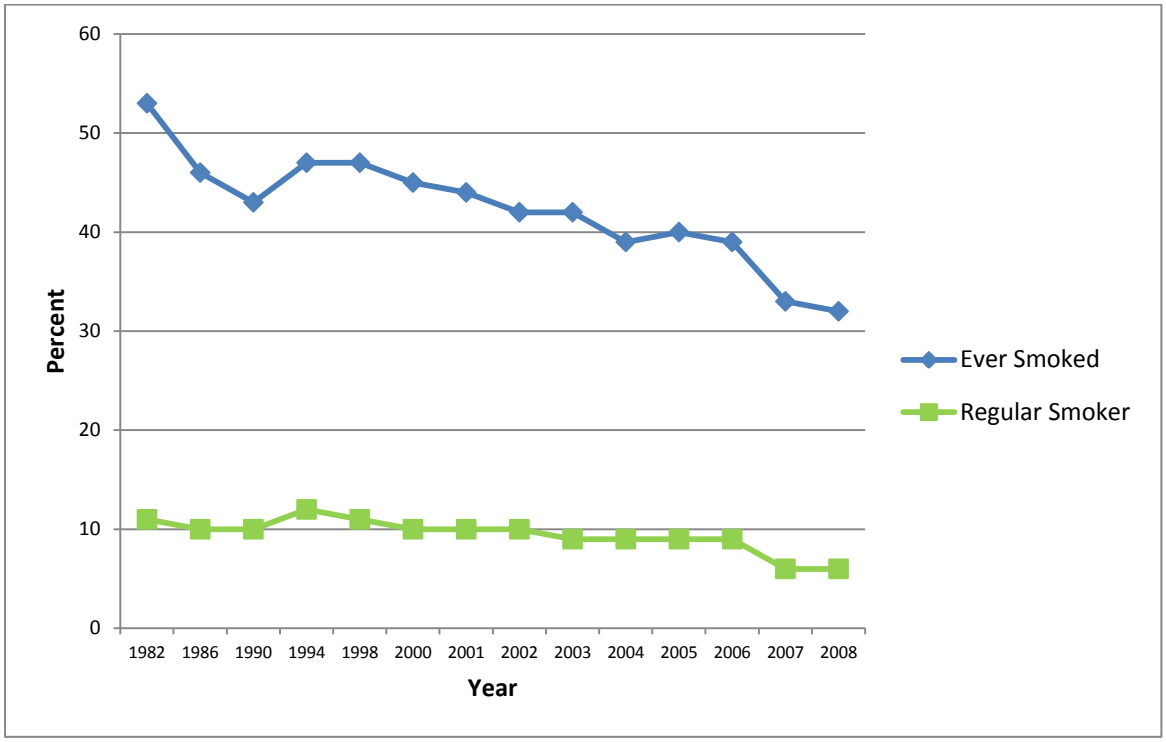
With regards to longer-term health effects the risk of disease is related to the length of time a person has smoked. Those who start smoking at a young age have higher age-specific rates for all types of tobacco-related cancers linked primarily to their earlier exposure to the harmful toxins from cigarettes (World Health Organisation International Agency for Research, 2004). Girls who start smoking at a young age are 79% more likely to develop bronchitis or emphysema in adulthood than those who had begun smoking as adults (Patel et al., 2004). Young smokers are also considered to have a greater-than average risk of developing heart disease (US Department of Health and Human Services, 2004) with one study finding smokers as young as 15 years displaying greater degrees of atherosclerosis than those who had never smoked (BMA Board of Science, 2007).

As a result of these factors it is important that measures are taken to try and break the cycle from youth to adult smoking.

1.3. Trends in youth smoking rates for the general population

1.3.1. Smoking rates for 11-15 year olds and 16-19 year olds

***Figure 1.1*. Prevalence of Smoking among 11-15 year olds in England from 1982-2008**



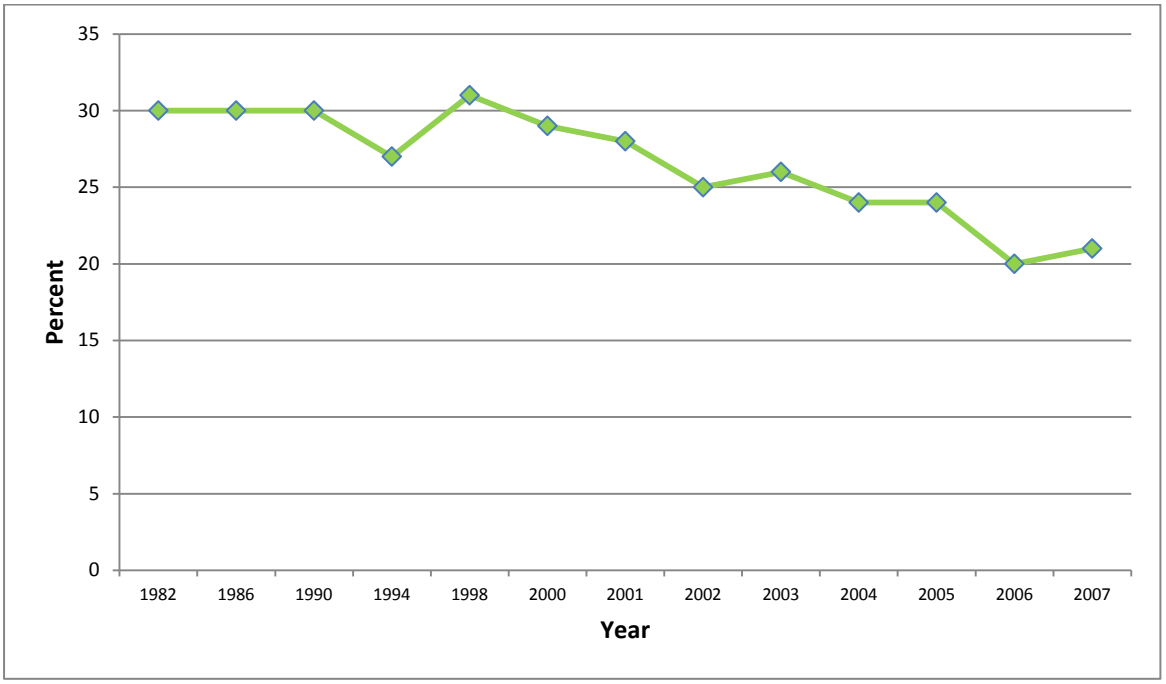
***Note*. Data from The NHS Information Centre, 2009.**

Currently a third (32%) of 11-15 year olds in England have tried smoking at least once (The NHS Information Centre, 2009). This rate is the lowest recorded by an annual survey conducted in England on smoking drinking and drug use among young people, since it was first conducted in 1982, when the smoking rate was 53%.

Regular smoking rates (smoking at least once a week) amongst 11-15 year olds in England, have started to take a slight downward shift since the start of the new millennia after remaining constant for much of the 1980s and 1990s (The NHS Information Centre, 2009). The rate of regular smoking has nearly halved since the mid 1990s falling from 13% in 1996 to 6% in 2008 (The NHS Information Centre, 2009). This rate is well within the target proposed by the Government White Paper, 'Smoking Kills' (Department of Health, 1998), to reduce the prevalence of regular smoking in the 11-15 years age range from a baseline of 13% in 1996 to 11% in 2005 and 9% in 2010.

The prevalence of regular smoking also increases with age. One in seven (14%) of 15 year olds say they smoke at least once a week, compared with less than 0.5% of 11 year olds (The NHS Information Centre, 2009).

***Figure 1.2*. Prevalence of Cigarette Smoking among 16-19 Year Olds in Great Britain from 1982-2007**

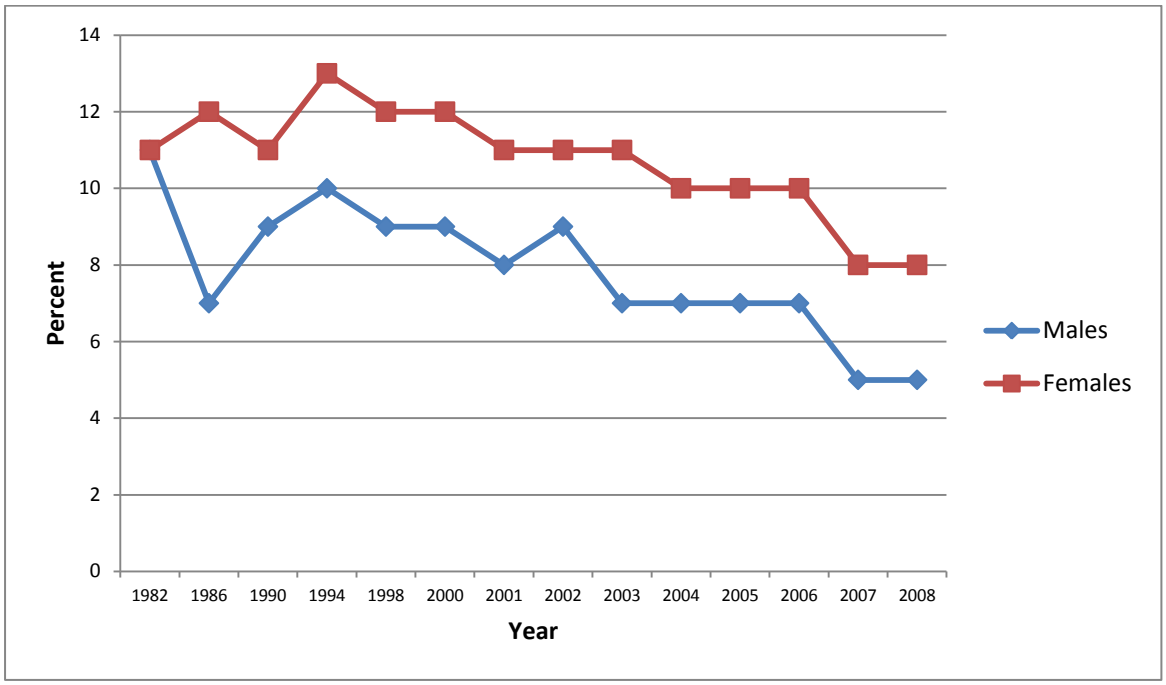


***Note*. Data from The Office for National Statistics, 2009.**

Smoking rates among older teenagers have also taken a downward turn since the start of the new millennia. Smoking prevalence among 16-19 year olds in 2007 was 21%.

1.3.2. Gender differences

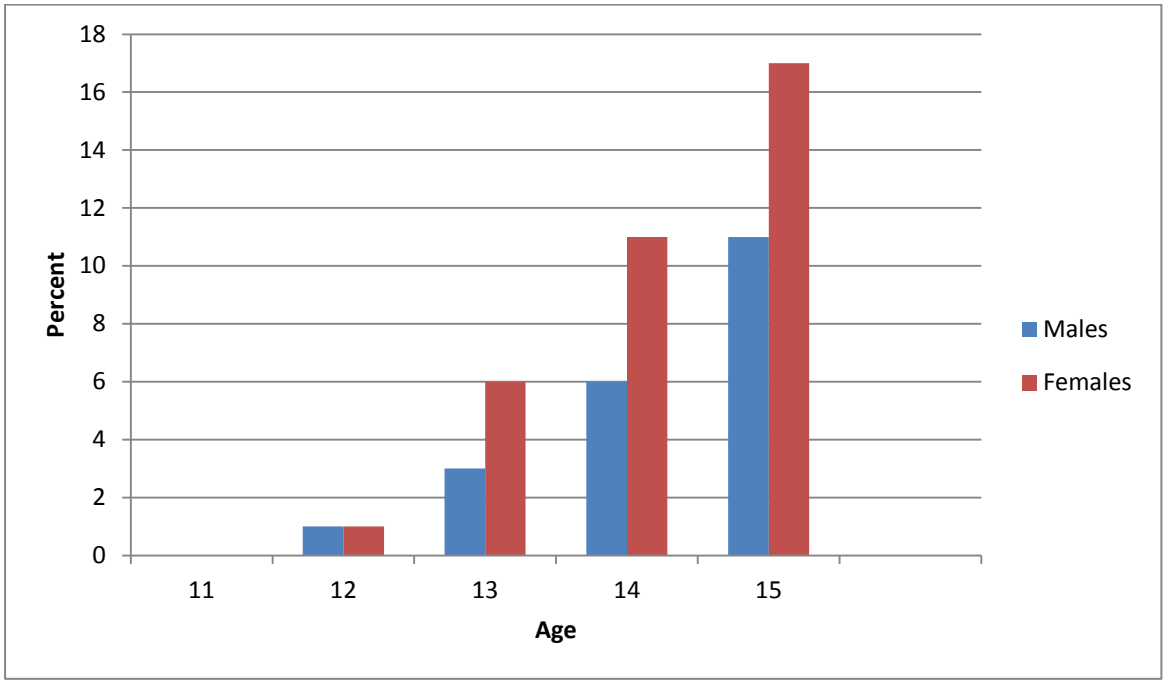
***Figure 1.3*. Prevalence of Regular Smoking among 11-15 Year Olds in England from 1982-2008 by Gender**



***Note*. Data from The NHS Information Centre, 2009.**

Following trends over the last twenty years, 11-15 year old girls are more likely to smoke regularly than boys. Rates for 2008 were 8% for girls and 5% for boys.

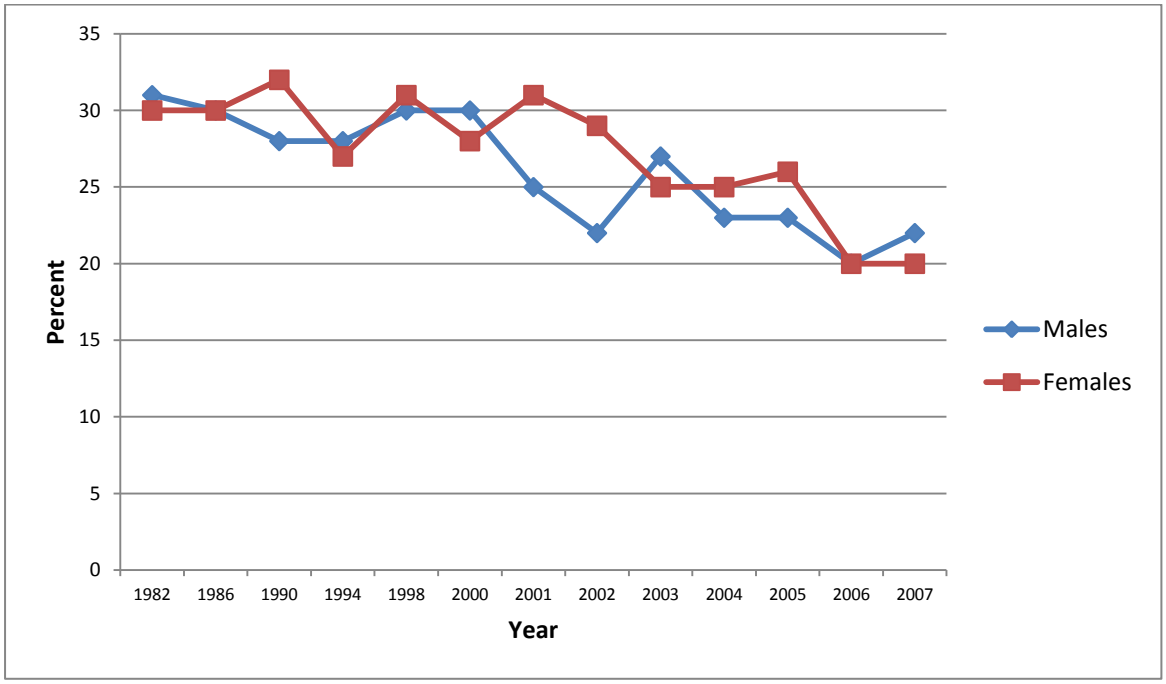
***Figure 1.4*. Smoking Prevalence among 11-15 Year Olds in England by Age and Gender**



***Note*. Data from The NHS Information Centre, 2009.**

It can be seen from figure 1.4 that higher rates of regular smoking among females become apparent at 13 years old. Prior to being 13 years old, rates were similar between both sexes.

Figure 1.5. **Smoking Prevalence among 16-19 Year Olds in Great Britain from 1982-2007 by Gender**



Note**. Data from the Office for National Statistics, 2009.**

Smoking prevalence among 16-19 year old males and females over the last couple of decades has fluctuated but has predominantly been higher in females. However, in 2007 the rate was slightly higher in males at 22% compared with 20% for females.

1.4. Young people and smoking cessation

A survey conducted in England found that 36% of school pupils that are regular smokers would like to stop smoking and almost two thirds (64%) had tried to give up smoking (The NHS Information Centre, 2009). Pupils who had smoked regularly for more than a year were more likely to have tried to give up smoking and failed (70%) compared to those who had smoked regularly for less than a year (54%). They were also more likely to

want to give up smoking altogether (44% compared to 24%). Common reasons cited by young people to quit smoking include the unpleasantness of the act, parental reactions, health considerations, appearance effects, finances, values and religious views (DeLorme, Kreshel & Reid, 2003).

A survey conducted in England found that out of those pupils that had asked for help or used services to stop smoking, the majority had asked family or friends for assistance (27%) followed by using Nicotine Replacement Therapy (NRT) products (10%). Very few sought help from the NHS (2% saw their GP, 1% called the NHS helpline and 1% used the NHS Stop Smoking Service). Only 21% of ex smokers in the survey had tried one or more sources of help compared with 63% of current smokers, which indicates that many of them stopped without any difficulty and may not have seen themselves as smokers at all (The NHS Information Centre, 2009). Moffat and Johnson (2001) found that the strategies used by some young people to quit in their study were based either on personal experience or on observing others who had quit successfully. Most participants in their study preferred cutting back gradually rather than quitting 'cold turkey', and several reported having switched to lighter brands.

Research has shown that young people often do not have a comprehensive understanding of the process involved in quitting smoking, which affects their chances of quitting smoking successfully (Moffat & Johnson, 2001). For example, many are unaware that repeated quit attempts are often needed before quitting smoking successfully. As a result studies have found that young regular smokers often feel disheartened and frustrated about quitting smoking due to previous failed quit attempts, emphasising the futility and 'wasted time', which impacts on their motivation to try again (Moffat & Johnson, 2001; Balch, 1998).

McVea, Miller, Creswell, McEntarrfer and Coleman (2009) found that the process of quitting smoking can be physically uncomfortable, emotionally distressful and socially

isolating for some adolescents. For example, they found that few parents actively supported their child during quit attempts and smoking friends and other peers undermined them. Gary, Grogan, Gough and Conner (2008) discovered that in order to resist smoking, participants highlighted the need to provide excuses to peers and some were considered more legitimate than others (e.g. an interest in sport for boys). McVea et al. (2009) found that successful quitters had to have emotionally compelling and inescapable quit reasons and had to establish new, non-smoking friends and completely redefine themselves. Although the researchers argued greater research needs to be conducted into the area, they concluded greater motivation, mature problem-solving skills, and a willingness to supplant their smoking friends, characterised successful quitters.

Also research has found that young people can often be in conflict regarding stopping smoking. For example, Moffat and Johnson (2001) found that although there was an urgency regarding the need for stopping smoking this was not always matched by a want or desire to quit. Excuses to postpone the quit attempt were often used, such as waiting for exams to be over or when feeling less stressed. Others felt certain life milestones provided better times to quit, such as having children. It was discovered that these excuses often arose after previous failed quit attempts. However, even then young people still germinated plans to quit.

Overall it appears that although young regular smokers may be keen to quit, previous difficult experiences of cessation and negative repercussions involved (e.g. jeopardising of social relations with peers), could thwart attempts to quit successfully.

1.5. Government measures to reduce youth smoking rates

The government has developed a number of measures over the years to help reduce smoking rates among young people. The White Paper, ‘Smoking Kills’ was developed in

1998 because it was recognised at the time that unless action was taken, hundreds of children would continue to take up smoking each day (Department of Health, 1998).

A new set of targets to reduce smoking prevalence were outlined in the document, to reduce smoking rates from a baseline figure of 13% in 1996 to 9% in 2010. A range of tobacco control measures, targeting for example, youth access and exposure to tobacco, were introduced to help meet these new targets. These included, minimal tobacco advertising in shops, tough enforcement on under age sales, proof of age cards and strong rules on the siting of cigarette vending machines.

Following on from 'Smoking Kills', the Government White Paper, 'Choosing Health: Making Healthy Choices Easier', published in 2004 (Department of Health, 2004), continued to make smoking a legislative priority. It outlined a comprehensive six strand strategy which is currently used by the Department of Health. The strategy involved i) assisting smokers who want to quit with easily accessible support ii) reducing tobacco promotion iii) using innovative media education campaigns iv) regulating tobacco products v) reducing exposure to second hand smoke and vi) maintaining a high price for tobacco products and tackling smuggling.

Supporting this strategy there was a change in legislation on October 1st 2007, to raise the legal minimum age of tobacco purchase from 16 to 18 years (Health Act, 2006). It is hoped that combining this legislation with measures to address adult smoking as well (e.g. the smokefree legislation preventing smoking in enclosed public places introduced on July 1st 2007 [Health Act 2006] and most recently the Health Act 2009, to remove tobacco displays in shops and to restrict the sale of cigarettes from vending machines) will help in creating a new social landscape where smoking is increasingly viewed as an anti-social activity, thereby reducing its appeal to both young people and adults alike. Researchers have argued that for any message or strategy to be successful with adolescents it must not be seen to be

specifically targeting youth (Hill, 1999; Sandford, 2008). Instead the aim should be to de-normalise smoking in society as a whole because this i) implicitly communicates to youth that smoking is an unacceptable behaviour for all members of a society (the more visible smoking is, the more it is perceived by adolescents as socially acceptable and normal) ii) decreases the amount of negative role modelling to youth and iii) present youth with less opportunities to smoke (Alesci, 2003). By limiting where individuals can smoke in the community substantially changes social norms for tobacco use and as health psychology models such as the Theory of Planned Behaviour (Ajzen, 1991) propose, such social norms can have a significant influence on smoking behaviour. Research has supported this because it has been shown, for example, that when youth tobacco-access interventions such as minimum age sale laws and sanctions against retailers are embedded in a comprehensive programme tackling adult cessation (including restrictions on smoking at work and in public places, advertising bans, taxation, media campaigns and education) they are more effective in reducing youth smoking rates (The Health Development Agency, 2004).

NHS Stop Smoking Services were developed by the Government following the 'Smoking Kills' White Paper, as part of a comprehensive tobacco control strategy. The service includes the provision of behavioural support from a stop smoking advisor in combination with stop smoking medication, such as NRT. Data for 2008/09 show that 20,823 of under 18s set a quit date with Stop Smoking Services and that success rates of giving up smoking generally increased with age (39% for those aged under 18, to 53% of those aged 60 and over) (The NHS Information Centre, 2009). Denscombe (2007) found underage smokers (those under 16 years) have not had the level of access to smoking cessation services that is warranted in terms of i) the prevalence of smoking among children ii) their apparent willingness to use such services and iii) the particular value of quitting smoking while young. He also argued the need for tailoring the approach to a younger population because as the

data shows the success rates are not very high. A recent evaluation of NHS smoking cessation services in Scotland found low quit rates (Gnich, Sheehy, Amos, Bitel & Platt, 2008). However, the authors acknowledged low participant numbers citing the difficulties of undertaking 'real-world' evaluations but concluded more action is needed to develop environments which enhance young smokers' motivation to quit and their ability to sustain quit attempts.

1.6. Tackling hard-to-reach groups and reducing health inequalities

It is apparent that the Government is committed to reducing youth smoking and recent trends in smoking rates would suggest that generally their measures are starting to see fruition. However, there are groups of the adult population who have a greater likelihood of smoking and who have been more difficult to target in the past, thus often being referred to as 'hard-to-reach'. These include individuals from lower socioeconomic groups and certain ethnic groups. Children of adults from these groups are vulnerable to repeating the same cycle as their parents because research has shown that children are more likely to smoke if one or both of their parents smoke (Royal College of Physicians, 1992). As Scheffels (2009) states, reducing tobacco consumption further will depend on the ability of health authorities to develop methods and ways of communicating that address young smokers and young smokers from low-status groups in particular.

1.6.1. Social and economic deprivation

It has long been established that adult smoking rates are correlated with social and economic deprivation. For example, those from manual groups have higher smoking rates

than those from non-manual groups (25% compared to 16% in England 2007) and individuals living in more socially deprived areas have a 40% greater chance of being classified as 'hardcore smokers' than those in more affluent areas (Office for National Statistics, 2009; Jarvis, Wardle, Waller & Owen, 2003).

There is evidence to suggest that smoking by adolescents is also inversely associated with socioeconomic status (Fleming, Hyoshin, Harachi & Catalano 2002; Shucksmith & Hendry, 1998). In a recent survey in England where the number of books in the home and eligibility for free school meals were used as proxy measures of socio-economic status, it was discovered that pupils who had books at home were less likely to be regular smokers than pupils who had no books at home. Pupils who got free school meals were more likely than others to be regular smokers (odds ratio=1.69). No significant association was found with the proportion of pupils eligible for free school meals within the school (The NHS Information Centre, 2009). One of the most socially deprived and excluded groups in society who are particularly vulnerable to smoking are children who are looked after by local authorities. 69% of 11-17 year olds who were in residential care were smokers and 22% in foster care were smokers (Office for National Statistics, 2003).

Research exploring the relationship between smoking and socioeconomic factors has found possible reasons for the association between the two. For example, studies have found that smoking is used as a coping mechanism to deal with life stressors such as debt, unemployment, parenting (for women with childcare responsibilities) and work (often reported by men) (Copeland, 2003; Taylor, Langdon & Campion 2005). Also stressful events would hamper quit attempts (Wiltshire, Bancroft, Parry & Amos, 2003). Smoking is also often a cultural norm within lower socioeconomic groups both within social and work contexts and interviews with smokers from these groups have found that it is often easier to be a smoker than a non-smoker (Stead, MacAskill, MacKintosh, Reece & Eadie, 2001).

1.6.2. Ethnic background

The Health Survey for England 2004 (The NHS Information Centre, 2006) found that among adults, Bangladeshi and Irish men have the highest smoking rates (40% for Bangladeshi men and 30% for Irish men compared to 24% for the general population). Rates have fallen for the general population men and Irish men since the last survey in 1999 but there have been no significant changes for other minority ethnic groups (a drop of 9% for Irish men and 3% for the general population).

The pattern of cigarette smoking was very different among women from minority ethnic groups. Rates of cigarette smoking were highest among Irish women (26%), Black Caribbean women (24%) and the general population (23%). Among all other minority ethnic groups the rates were low, ranging from 2% among Bangladeshi women and 10% among Black African women. Again rates had dropped among the general population and Irish women but there were no significant differences among the minority ethnic groups.

With youth smoking rates unfortunately national data on youth smoking according to ethnicity is not recorded. However, a recent pupil survey conducted in England did not find ethnicity to be associated with being a regular smoker. This was different to previous years when pupils from most ethnic minority groups were less likely to be regular smokers in comparison to White pupils (The NHS Information Centre, 2009). When taking national data for the youngest adult age group of 16-34 years, this again shows that Bangladeshi males have a higher smoking rate than the general population (35% compared to 32%) (The NHS Information Centre, 2006). Among females in this age group, Black Caribbean and Irish groups have the highest rates (44% and 35% respectively compared to 28% for the general population) and Bangladeshis the lowest rates at 1%.

With regards to explanations for the contrasting rates among individuals from different ethnic backgrounds, again socioeconomic factors can have an influence. For example, the Bangladeshi population for whom male smoking rates are the highest, is one of the most deprived in the UK (Modood et al., 1997) and as stated earlier there is a strong correlation between smoking and deprivation. This can be combined with cultural factors because it is well established that in any population, tradition, culture and the family role, play an important part in creating values and norms around smoking. These values and norms can then in turn impact on smoking uptake and behaviour (Bush, White, Kai, Rankin & Bhopal, 2003).

In regards to smoking cessation, the use of NHS Stop Smoking Services by ethnic minority groups has been increasing over recent years (increasing from 7,366 setting a quit date in 2001/02 to 45,228 in 2008/09) (The NHS Information Centre, 2009). Unfortunately data according to age and ethnic group is not available but overall among the black and minority ethnic groups, the Asian or Asian British ethnic group had the largest number of people setting a quit (19,550) and the highest number of quitters (9,394). The success rate of giving up is highest among the White group (51%) and lowest among those in the Black and Black British ethnic group (45%). Although overall there were more women setting a quit date through the services than men, among ethnic minority groups the opposite was reported. Only 15,634 women from ethnic minority groups set a quit date in 2008/09, compared to 29, 594 men, which is representative of smoking prevalence.

1.7. Taking a critical health psychology perspective

As a result of factors such as social and economic deprivation having an impact on smoking rates and leading to health inequalities, it is important that the Government addresses these when developing measures to reduce smoking rates. This would tie in with the critical health psychology perspective which recognises the importance of addressing the complex moral, emotional, ethical and political issues underpinning peoples' experiences of health and illness (Crossley, 2007). Although there is a rationale for the recent measures to help de-normalise smoking as a whole in society, there are concerns that the greater underlying reasons as to why individuals smoke, for example, dealing with social and economic deprivation, are not being addressed. As a result some commentators argue that such measures may only further exacerbate the sense of stigmatisation and exclusion that individuals from these groups experience (Haines, Poland & Johnson, 2009; Scheffels, 2009).

Scheffels (2009) found that the young adults in his study talked about themselves in defensive smoker identity terms. Participants appeared resistant to wanting to quit smoking as a result of feeling pressurised by government measures, making it clear it would only be out of personal choice. Scheffels (2009) argued that the negative focus on smoking in public discourse was rejected and counter-communities were constructed which involved a polarisation between smokers and non-smokers. Farrimond and Joffe (2006) discovered that smokers with higher social status tended to distinguish themselves from negative smoker stereotypes and hence challenged the grounds upon which stigmatisation was based but lower social status smokers more often seemed to accept the negative aesthetic as well as the 'outcast' status. As a result while stigmatisation may push higher social status smokers to quit, it may fail to engage lower social status smokers thereby perpetuating health inequalities as opposed to removing them (Scheffels, 2009).

It can be seen that carrying out qualitative research into the influences on youth smoking, which aims to elicit individuals' perspectives on their environments and their lived

experiences, is important in this area. Such research can then help inform more comprehensive measures to help reduce youth smoking. Morrow (2001) argues that a large amount of epidemiological attention has been paid to links between material inequalities in childhood and inequalities of health outcomes in adulthood, however these studies cannot explain why, or how, deprivation in childhood is linked to poor health outcomes in later life nor can they trace the processes involved:

> Health promotion initiatives with children and young people have tended to be based on questionnaire surveys of risk behaviours. These are useful for identifying broad trends in health behaviours like drinking and smoking (i.e. behaviours that give adults cause for concern) but cannot elicit the meaning, perspectives and social contexts of these behaviours.
>
> Morrow (2001, p.256).

It is argued that the complex interactive relationship between individual experience, social action and the way in which societies are organised at a macro level needs to be investigated more and research about children's lives is essential if policies and programmes are to become more responsive and relevant to their concerns and needs (Boyden & Ennew, 1997), As Backett-Milburn and McKie (1999) state, researchers need to create the potential for children to have their own ideas and explanations heard and understood.

A literature review into the psychosocial influences on youth smoking will now be presented to ascertain which variables are considered to have an influence on youth smoking and to explore what is currently known about the underlying processes at work between these variables.

1.8. Review of psychosocial influences on youth smoking

It is recognised that drug effects underpin smoking behaviour but a complex interplay of psychosocial factors appear to have an influence on who starts smoking in the first place, who gives up and who continues (Jarvis, 2004). Some of these factors may be more pertinent during experimentation and initiation while others may have more of an impact on maintenance of smoking behaviour.

1.8.1. Social factors

1.8.1.1. Familial influences

Studies have reported a strong correlation between smoking and family smoking behaviour (Fleming et al., 2002; Conwell et al., 2003; Vink, Willemsen & Boomsma, 2003; Engels, Vitaro, Blokland, De Kemp & Scholte, 2004; Kandel, Kiros, Schaffran & Hu, 2004). Children who live with other smokers are more than twice as likely to become smokers than children living in non-smoking households (Eiser, Morgan, Gammage & Gray, 1989). One study even showed that children living in a non-smoking household are 74% less likely to start smoking (Wakefield et al., 2000). As a result parental smoking is often considered the first influence on experimentation with cigarettes, particularly for younger children (Charlton et al., 2010). For example, when the female participants in a qualitative study conducted by Moffat and Johnson (2001) recounted their initial experience of smoking they would frequently turn to stories of their mothers' smoking. The author describes how the participant storyteller links her mother's nicotine addiction with her own smoking and hints that she may well develop a similar smoking pattern to that of her mother.

Although a causal relationship cannot be determined, social learning theory dictates that individuals learn behaviour via observational learning of the social factors in their environment (Bandura, 1977) so there is the risk that young people could model the smoking

behaviour of the adult smokers around them (Marks, Murray, Evans & Willig, 2000). Curiosity often sparked by observations of family members who smoked regularly is a reason often cited by young people for a contributory factor in initiating smoking (DeLorme et al., 2003; Milton, Woods, Dugdill, Porcellato & Springett, 2008; Greenlund, Johnson, Webber & Berensen, 1997). Also growing up in an environment where adults smoke could lead to normative beliefs (Ajzen, 1991) among young people that adults smoke. This is risky given that experimentation with smoking has also been found a way of asserting adulthood among young people (Jarvis, 2004; Mullen, 2000; Scheffels, 2009). DeLorme et al. (2003), argue that as opposed to familial influences being a direct cause of the first incident of experimentation, repeated exposure to smoking in the family, the curiosity factor around observing family members smoking and the easy accessibility to cigarettes in the household, appears to have a cumulative role in the onset of smoking in a young person. Hence familial influence may be more important at the preparation stages with peer influences eventually having more of an influence at the actual time of experimentation.

Parental attitudes as well as behaviour are considered a risk factor for young people to start smoking (BMA Board of Science, 2007). The more likely children anticipate disapproval and negative attitudes for smoking from their parents the less likely they are to become smokers (Jackson & Dickinson, 2006; Aaro, Haukness & Berglund, 1981). A recent survey discovered that the more smokers in a household the less likely children will anticipate a negative attitude towards their smoking from their families (55% of pupils living with 3 or more smokers thought their families would try to make them stop smoking compared with 75% of pupils living with non-smokers only) (The NHS Information Centre, 2009). A qualitative study conducted by DeLorme et al. (2003) found that young people talked of experiencing guilt when initiating smoking and feared their parents' reactions, often engaging in rituals to conceal their smoking behaviour from their family.

Familial smoking could also have an effect on cessation attempts of young people. For example it was discovered that smokefree homes almost doubled the chances of quitting for children who had started smoking (Farkas, Gilpin, White & Pierce, 2000). Also not having family members that smoke provides one less potential source of cigarettes for young children to maintain their smoking behaviour. For example, currently in England 10% of pupils are given cigarettes by their siblings and 6% by their parents (The NHS Information Centre, 2009).

1.8.1.2. Peer influences

Traditionally peer pressure has been considered a risk factor for youth smoking. This involves the offering of cigarettes to individuals by peers which is followed by coercion or teasing if the offer is resisted. For example, participants in DeLorme et al.'s (2003) study frequently reported being reluctant to smoke but then 'finally giving in' to the nagging or verbal insistence of a peer who was often said to be a 'best friend' or a 'good friend'. In some cases the 'friend' was also a novice who wanted to share the risk of a first cigarette with a trusted companion; in other cases, the persuasive pal was already a smoker.

However, a growing number of qualitative studies into the areas have not found direct peer pressure to be so influential. For example, Alexander, Allen, Crawford and McCormick (1999) found that very few of their teen participants described peer pressure when recalling the circumstances of their smoking initiation. The rare times direct pressure was described it was by males who said their manliness had been ridiculed if they were reluctant to smoke.

Denscombe (2001) and Nichter, Nichter, Vuckovic, Quintero and Ritenbaugh (1997) found the young participants in their studies largely rejected the idea that they were victims of peer pressure. This is because it went against their ideas of individual autonomy and self-determination which they valued highly. Being a 'victim' also defied their active and

conscious collaboration in joining with the group. Finally, it did not take into account the multiplicity of peer groups and the flexibility of their composition (Denscombe, 2001). Participants described the fluidity of their peer groups allowing them to hang out with smoking friends when they wanted to smoke but not at other times. Hence if they did feel pressurised they could spend time with other groups and still not be friendless, thus diluting the pressure to conform by a particular peer group.

Instead qualitative studies have identified a broader depth to the influence peers can have on youth smoking (Arnett, 2007). Peer bonding rather than pressure is now considered to be a major predictor of onset of adolescent smoking (Conrad, Flay & Hill, 1992). This involves the seeking of group acceptance and peer approval (DeLorme et al., 2003; Moffat & Johnson, 2001; Alexander et al., 1999; Nichter et al., 1997) as opposed to an overt pressure to smoke. For example, DeLorme et al. (2003) found that on numerous occasions peer pressure was not direct but actually internally motivated by a participants' desire to be accepted as part of the group or to obtain approval of a particular peer. Attempts to gain group acceptance were often associated with major life transitions that required making new friends and seemed to heighten individuals' vulnerability (such as moving to a new area, changing schools). Although participants did not feel goaded to smoke they chose to smoke as they felt it would make them less of an outsider and those who smoked to obtain approval seemed to be motivated by insecurity and/or need for attention.

Possible reasons for this include that, Social Identity Theory states that individuals of a group will modify their behaviour to fit the norms that are central to the social identity of the group and homogeneity of a group (Abrams & Hogg, 1990; Baumeister, 1990; Kobus, 2003) and this could be heightened in early adolescence when identity issues become prominent (Berndt, 1996). Also the social image associated with smoking for adolescents is important. If adolescents consider smokers to be tough, cool or attractive they are more likely

to join a peer group with smoking members to become associated with that particular image characteristic. Spijkerman, Van Den Eijnden and Engels (2007) explored the differences between smoking and non-smoking adolescents' perceptions of their smoking and non-smoking peers. They found that adolescent smokers were more likely to perceive their smoking peers as better adjusted, cooler and more attractive. They were also more likely to perceive their non-smoking peers as less well-adjusted, less rebellious, less cool and less attractive. Likewise for non-smokers the desire to conform to a non-smoking norm is very important. For example, Lucas and Lloyd (1999) found that if a female peer took up smoking, she would almost inevitably leave their group to join other smokers.

Other ways in which peer influence can have an effect on youth smoking is through curiosity and the opportunity to experiment. Similar to familial smoking, ongoing exposure to peer smoking can lead to curiosity about the behaviour. However, curiosity over peer smoking is considered to be more instrumental in the moment of experimentation (DeLorme et al., 2003; Moffat & Johnson, 2001; Lucas & Lloyd, 1999, Milton et al., 2008). For example, Hahn et al. (1990) found that although the majority of smokers were with close friends the first time they smoked (54%, compared to 7% alone), the majority (43%) had asked for a cigarette rather than having it suggested to them, mainly due to curiosity.

With regards to opportunity to experiment, having peers that smoke presents greater opportunity to smoke (DeLorme et al., 2003; Arnett, 2007). This can be influential both in regards to initiation and maintenance of smoking behaviour. For example, studies have found that once young people experiment with cigarettes their smoking peers assign the social identity of a smoker to them thus offering them cigarettes, which they find difficult to refuse (Nichter et al., 1997; Lucas & Lloyd, 1999). Participants in Moffat and Johnson's (2001) study also emphasised the ready availability of cigarettes with some mentioning they do not have to actively seek cigarettes. This ties in with findings from a survey in England, which

found a large majority of pupils (58%) are given cigarettes by their friends (The NHS Information Centre, 2009). As Gilpin et al. (2001) concluded from their results from the California Tobacco Surveys, until peer approval of smoking and sharing cigarettes is reduced, it will be difficult to significantly lower adolescents' access to cigarettes.

1.8.1.3. Community influences

Community influences which can impact on youth smoking, include the school environment and local tobacco retailers.

In regards to the school environment, having a comprehensive range of school policies on smoking and enforcing them, can have an impact on reducing youth smoking (Moore, Roberts & Tudor-Smith, 2001; Wakefield et al., 2000; Charlton & While, 1994). For example, having a policy restricting staff smoking on school grounds is important because staff displaying their smoking behaviour to their students can make smoking seem safe and acceptable (Poulsen et al., 2002; Charlton & While, 1994). With the smokefree legislation in enclosed places in England there may be more of a risk of students seeing staff smoking around the school grounds. Currently 90% of schools in England have a policy on adult smoking and for 98% of them the policy applies outside of school hours as well. 87% report smoking is prohibited anywhere on school premises (The NHS Information Centre, 2009). Also having a school policy on restricting smoking among pupils and providing education on smoking could assist with reducing youth smoking (Charlton & While, 1994; Reid, McNeil & Glynn, 1995; Pentz et al., 1989). Currently 84% of schools in England have policy on student smoking and nearly 100% provide lessons on smoking. However, it was discovered that only 61% of pupils recalled having lessons on smoking in the last 12 months (The NHS Information Centre, 2009). By enforcing these restrictions this could help convey to young

people that smoking is a negative habit which is not a normalised and accepted behaviour in society, thus shaping their social norms around smoking.

Secondly the school environment can also have an influence on youth smoking through the school culture. School culture pertains to the culture and ethos of the school; its values, attitudes and behaviour characteristics (Scheerens, 2000). Aveyard et al. (2004) developed a measure for school culture called added 'value added education'. They concluded in their study that school culture is an independent risk factor for adolescent smoking and that schools that provide effective support and control might protect pupils from smoking. Survey data in England has found that pupils who are excluded or had truanted from school, were more likely to smoke (odds ratio of 2.45 and 2.38 respectively) (The NHS Information Centre, 2009) and school culture could partly provide a possible explanation for this.

Retailers of tobacco can also have an influence on youth smoking by providing access to cigarettes. A recent survey among 11-15 year old pupils discovered that since the implementation of legislation increasing the tobacco purchase age from 16 to 18 years in England, 55% of regular smokers still bought their cigarettes from shops. Although this is a drop from the 78% who purchased cigarettes from shops in 2006, the figure is still high and still makes shops one of the major sources of supply of cigarettes for young people (The NHS Information Centre, 2009). 39% of pupils said they found it difficult to buy cigarettes, which has increased from 24% in 2006 and although 57% were refused them at least once in the past year, 43% of pupils who tried to buy cigarettes from shops were always able to do so (The NHS Information Centre, 2009). Retailers have a legal and moral duty not to provide cigarettes to underage youth and the government can assist with enforcing the law, for example, by publicising the legislation more amongst retailers, conducing regular audits of

test-purchasing and prosecuting regular offenders (National Institute for Health and Clinical Excellence, 2008).

1.8.2. Psychological factors

1.8.2.1. Attitudes

Adolescents who express positive attitudes towards smoking are considered more likely to initiate tobacco use and to also progress to regular or heavy use at a faster pace than those with less positive attitudes (Andrews & Duncan, 1998). Also beliefs in certain positive outcomes of smoking can override any negative beliefs regarding health consequences, for example adolescents who see cigarettes as a way to handle negative feelings are more likely to ignore the long-term health consequences of smoking (Samet & Yoon, 2001). It can be argued that this may be because the perceived positive effects are more pertinent during the adolescent stage of life, for example, coping with stress is more relevant for teenagers than concerns about ill-health, which are more related to later years of life. Swan, Murray and Jarrett, (1991) argue that once the effect of strong social influences, which were described earlier, also come into play then knowledge of health risks counts for little.

Qualitative studies have shown that the positive beliefs and attitudes young people have about smoking prior to initiation do not necessarily hold true after experimentation (Moffat & Johnson, 2001; DeLorme et al., 2003; Johnson, Kalaw, Lovato, Baillie & Chambers, 2004). A survey in England found that over a third of pupils thought it was acceptable to try smoking (34%) and nearly a fifth (18%) thought smoking only harms people who smoke a lot (The NHS Information Centre, 2009). However, studies have found that some smokers express disappointment after initiation of smoking. For example, those who thought it would make them look cool had not anticipated the initial smell, taste and coughing

involved (DeLorme et al., 2003). Hence the humiliation they felt instantly shattered any positive outcome they had hoped to achieve. Also many smokers had not considered the possibility of getting addicted, which was often reassured by their smoking peers at the time of initiation (Moffat & Johnson, 2001; Johnson et al., 2004; Lucas & Lloyd, 1999). Hence once they realised they were addicted they felt regret. On the reverse side there are individuals who will not acknowledge they are addicted (Moffat & Johnson, 2001). These findings can have important implications for cessation.

1.8.2.2. Identity

Lloyd and Lucas (1998) state that when young people are asked what they think about smoking, their ideas and images of smoking revolve frequently around identity; who one can be or become by smoking. Erikson (1950) believed that identity is a major developmental issue in adolescence and that experimentation is part of a search for identity, and Plumridge, Fitzgerald and Abel (2002) argue that smoking uptake and smoking refusal are both important identity statements. Qualitative studies have explored the experience of constructing an image or identity through smoking in young people (Scheffels, 2009; DeLorme et al., 2003; Moffat & Johnson, 2001). For example, DeLorme et al. (2003) found that participants initiated smoking to be rebellious; to defy parental and legal rules about the use of tobacco, and to appear cool, independent and mature. Scheffels (2009) identified the desire to be adult-like, remarking that participants used smoking as a prop for staging the self in a performance of adulthood. Social influences are also strongly linked with the construction of identity through smoking. For example, DeLorme et al. (2003) found peer influences and the construction of identity to be intrinsically connected. Participants in their study described efforts to construct or refine their image or presentation of self, or to 'be like' certain peers or other people in their everyday circle, who they perceived to have socially

desirable traits. Differences are perceived between smokers and non-smokers, for example, Lloyd and Lucas (1998) found that occasional smokers and those who were about to become regular smokers saw themselves as more fun-loving and less conforming than their non-smoking peers.

The period after initiation of smoking can present a time of identity conflict for some young people. This can result when the experience of smoking did not fulfil expectations or there were unanticipated consequences. For example, the female participants in Moffat and Johnson's study (2001) who had not expected to become addicted to smoking felt conflicted about being identified as a smoker because it was incompatible with some of their other lifestyle choices, such as athletic endeavours or singing. They reported being 'embarrassed' or 'not proud' of their smoking habit. Others who engaged regularly in the activity of smoking resisted the smoking identity because they felt in control of their smoking and did not identify themselves as being addicted. Given that the smoking identity of teenage girls is in the process of evolving it is argued that it is important for cessation interventions to be implemented before smoking is fully integrated into their notions of self (Lovato, Shoveller, Ratner & Johnson, 1998). Hence successful quitting can be enhanced by early intervention when smoking behaviour is less integrated into adolescents' repertoires (Kviz, Clark, Crittenden, Freels & Warnecke, 1994).

1.8.2.3. Personality factors

Research has shown that a novelty-seeking personality which is characterised by sensation-seeking behaviour, impulsivity and risk-taking behaviour can predict tobacco use during adolescence and early onset of smoking among adolescent boys (Wills, Vaccaro & McNamara, 1994; Wills, Windle & Cleary, 1998; Masse & Tremblay, 1997). Lloyd and

Lucas (1998) also discovered that a strong motivation to pursue fun was an important predictor of smoking uptake.

1.8.2.4. Affective factors

1.8.2.4.1. Stress

One of the most important reasons given for smoking by teenagers is to relax and reduce stress (Angus Reid Group, 1997). Nichter et al. (1997) suggest that 'stress' is a vague term used by adolescents to refer to a variety of factors such as being overwhelmed, anxious, or angry. Participants in Moffat and Johnson's (2001) study attributed stress to school, various social pressures, family conflict and family illness. High stress levels have been correlated with both initiating and maintaining cigarette use (DeLorme et al., 2003; Croghan et al., 2006). For example, research has shown college students increase their tobacco use during final exams compared to a neutral time period (Steptoe, Wardle, Pollard, Canaan & Davies, 1996; West & Lennox, 1992).

Studies have shown that individuals who attribute tobacco use as an important stress management practice, report more stressful situations and negative life events than non-smokers (Niaura, Shadel, Britt & Abrams, 2002; Siqueira, Diab, Bodian & Rolnitzky, 2000). Potential explanations could be that smokers are more likely to experience social and economic deprivation which leads to the stress. Wills and Shiffman (1985) suggest that individuals low in personal resources, such as self-esteem, feelings of mastery and social support, turn to smoking as it is the only available means of coping with stress. Also in regards to maintenance of cigarette use, nicotine withdrawal symptoms that smokers experience can be similar to the experience of stress. Hence once they have a cigarette they feel a sense of relief, which is supported by accounts in qualitative studies (DeLorme et al.,

2003). Therefore dealing with stress is often cited as a reason for maintaining smoking behaviour or postponing quit attempts (Moffat & Johnson, 2001).

1.8.2.4.2. Depression and negative mood

Depression has been found to be a predictor of smoking initiation and to be associated with nicotine dependence among young people (Escobedo, Kirch & Anda, 1996; Fergusson, Lynskey & Horwood, 1996; Fleming et al., 2002). UK data shows that young people with a diagnosis of depression were over five times more likely to be smokers than those without depression (Boys et al., 2003). There is also evidence to suggest that negative mood precedes smoking and vice versa (Croghan et al., 2006; Moffat & Johnson, 2001).

Other negative moods, such as boredom, have also been cited by adolescents as reasons for maintaining smoking behaviour (Stone & Kristeller, 1992; Hayes & Plowfield, 2007; Moffat & Johnson, 2001).

1.8.2.4.3. Self-Esteem

There have been mixed results concerning any association between self-esteem and smoking prevalence in young people (Barlow & Woods, 2009) and existing literature is inconsistent as to the exact nature of the relationship between self-esteem and tobacco use (Greenberg, Lewis & Dodd, 1999; Byrne & Mazanov, 2001). Several studies have found a direct relationship between low self-esteem and increased tobacco use in adolescents (Emery, McDermott, Holcomb & Marty, 1993; Abernathy, Massad & Romano-Dwyer, 1995). Other studies have found self-esteem to predict initiation of cigarette use but not subsequent smoking (Barlow & Woods, 2009).

1.9. Research on youth smoking and ethnicity

Overall it can be seen that there are a range of psychosocial influences that can impact on a young person's decision to smoke and also on their experiences of trying to stop smoking. However, the majority of studies which have been conducted to date within the UK have centred on the general White British population. There is a lack of studies exploring psychosocial influences and the experience of smoking generally for young people from different ethnic backgrounds.

It can be argued that exploring smoking behaviour with regards to ethnic origin is important because cultural background can dictate the creation of smoking values and norms which in turn can influence smoking uptake and behaviour (Bush et al., 2003). For example, a person's cultural background may influence their use of tobacco, attitudes towards tobacco and cessation and thoughts about health-related information (ASH Scotland, 2004). As a result research which explores attitudes, beliefs and values around smoking of young people from different ethnic groups, could help to inform smoking prevention and cessation initiatives, which is one way in which health inequalities could potentially be reduced (ASH Scotland, 2004). Sasco and Kleihues (1999) argue that part of the problem with current smoking prevention and cessation initiatives is that they have a uniform approach to diverse populations. For example, currently ethnic minority groups are not given special mention in national policies on smoking cessation. ASH Scotland (2004) recommends that professionals who provide tobacco education and smoking cessation initiatives, should create detailed profiles of the population living in their areas to help meet their needs more effectively. The National Institute for Health and Clinical Excellence (2008), also states there is a clear rationale for making sure that Stop Smoking Services cater adequately for black and minority ethnic (BME) groups. This is not to suggest that stereotyping and assumptions should be made about individuals based on ethnicity alone (e.g. the importance of other factors such as

socioeconomic status need to be considered) but that it is important to be aware of the influence that ethnicity may have on a person's smoking behaviour.

The Stop Smoking Service in which the researcher is based, is located in a deprived inner city borough which has a high Bangladeshi and Somali population. The Bangladeshi community comprise of 6.4% of the local population (Office for National Statistics, 2001). The 2001 National Census indicates that 1900 of local residents in the borough were born in Somalia. However, the latest predictions estimate 4000 residents, making it the second largest non-white ethnic community in the borough after the Bangladeshi population (Khan & Jones, 2002). The borough is the 19th most deprived in the country with a lower life expectancy than the national average. There are extremes of wealth and poverty in the borough with some very affluent areas but in the most deprived areas there are i) lower life expectancies ii) higher standardised mortality ratios (SMRs) for premature death from all causes and iii) lower levels of perceived good health ([redacted] PCT, 2006). It was discussed earlier how Bangladeshi adult males have the highest smoking rates in the country at 40% (The NHS Information Centre, 2006) and there are also reports of Somali males having higher smoking rates than the general population (Straus, McEwen & Croker, 2006).

A review of studies exploring youth tobacco smoking among the Bangladeshi and Somali population was conducted and no studies exploring youth smoking among Somalis were discovered. This may be because although there have been established Somali migrant communities in the UK since the 1800s, mass migration has not occurred until more recently in 1991 (Khan & Jones, 2002).Only one qualitative study exploring smoking among Bangladeshi youth aged 14-15 years was discovered, which was conducted by Markham, Featherstone, Taket, Trenchard-Mabere and Ross (2001). Although the study was published in 2001, data was collected for the study in 1995.

This study explored the meanings, function and prevalence of smoking amongst a sample of Bangladeshi smokers, non-smokers and ex smokers aged 14-15 years from the West Midlands. Findings indicated, for example, that smoking among the participants tended to be a covert activity hidden from older members of the community, particularly among Bangladeshi females who rarely smoked in public (those that did, did so in a locality in which they did not live). It was found that this behaviour was primarily influenced by beliefs regarding age and the cultural acceptability of smoking, whereby it was considered more acceptable for older men, and to a lesser degree older women, to smoke openly. This belief stemmed from elders' respected status in society where smoking in front of elders was deemed disrespectful. Females also feared the repercussions of being caught smoking more than males, arguing that women who smoke would get a bad reputation in the wider Bangladeshi community, which consequently could reflect badly on their parents' standing in the community. Males on the other hand were shown to be indifferent to parental reactions, being dismissive of parental ability to control smoking amongst young Bangladeshi men. The family was an important medium through which cultural norms and values associated with smoking were shaped and negotiated. For example, young Bangladeshi boys often learnt to smoke by observing male elders smoking, which ties in with the familial influences discussed earlier. However, the influence of wider society was also acknowledged. Both males and females discussed the role of smoking in facilitating social interactions, which supports the importance of peer influences discussed earlier. So even though smoking for females was a covert activity, they would smoke with peers because it facilitated social bonding and sharing. Males described how smoking cigarettes enabled them to 'join in with friends'. However, this is not to say participants would never smoke alone as they often did. Other reasons cited by both males and females for smoking, included, dealing with negative moods and situations such as boredom and stress, which supports the psychological influences

discussed earlier. Also the motivation for young Bangladeshi females to smoke often centred on issues regarding independence, autonomy and rebellion against parental and community expectations. Smoking was presented as a way to express the right to make choices about how to behave. This did not apply for males because they considered male smoking more commonplace and mundane and were indifferent regarding parental control, which does not lend itself to being used as a way to rebel. With regards to cessation and the reasons for wanting to quit smoking, parental factors, health, unpleasant effects, expense, changes in social interactions, playing sports and illegality were the main reasons cited by both males and females.

1.10. Rationale for study

As a result of findings from the review it was decided to conduct a qualitative study to explore the process of smoking from pre-initiation, initiation, maintenance and cessation for 16-17 year old male and female second-generation Somali, Bangladeshi and White British smokers. This is because these processes of smoking behaviour have not been investigated with Somali youth in the UK and have not been investigated with older Bangladeshi adolescents. Also the pre-initiation phase has not been studied with younger Bangladeshi adolescents. Hence it is felt that the explorative nature of qualitative research would be advantageous for this study to gain further insight into their experience of smoking for Somali and Bangladeshi adolescents.

Also as the Bangladeshi and Somali participants in this study will be second-generation, they will all share the experience of being born and raised in the UK. This will provide a different socio-cultural context to the study compared to the study conducted by Markham et al. (2001) because that study was conducted in 1995 and the majority of

Bangladeshi immigration to the UK occurred in the 1970s (Probert et al., 1992). As a result there may have been cultural changes in the experience of the second wave of young people who were born and bred in this country compared to the first wave.

The 16-17 years age group was selected because it is during the mid-to-late teens that the likelihood of becoming a regular smoker increases and the age of onset for Asian youth is generally later than with the general population (The NHS Information Centre, 2007; Office for National Statistics, 2006). Also previous studies with the general population have shown many teenagers often make quit attempts within a very short time of taking up smoking (McNeil, 1991) and so there is a greater likelihood of participants in this age group having had experience of cessation. Under 18 year olds were also selected because they would still not be legally regarded as adults in England (HM Revenue & Customs, 2010), as the intention was to explore young peoples' experiences. The legal age of tobacco purchase had also recently been increased from 16 to 18 years and so this age group would have been most affected by the change.

Bangladeshi male and female adolescents will be focused on for the study because as discussed, smoking rates in the UK are the highest among Bangladeshi adult males. The rates are also the highest among young adult males leading to concerns that young Bangladeshi males are emulating the behaviour of their elders. Although self-reported smoking rates among Bangladeshi women are low, there are concerns over the accuracy of data obtained from self-report measures from Bangladeshi women. This is because female smoking is considered taboo and shameful in Bangladeshi culture and therefore Bangladeshi females may not disclose their smoking behaviour. This is supported by the fact that anecdotal reports cite a rise in smoking rates among younger Bangladeshi females (The NHS Information Centre, 2006; Pooransingh & Ramaiah, 2001). Overall these trends among the younger Bangladeshi population are particularly concerning when considering that the Bangladeshi

population is one of the youngest in Britain with 38% aged under 16 and only 3% aged over 65 and unlike with other ethnic groups the smoking rates for Bangladeshis increase with age (The NHS Information Centre, 2006). Hence if young Bangladeshi males continue to follow the high smoking rates of adult males and younger females increasingly take up the habit this is a worrying situation for the future, with potentially fear reaching negative consequences for the Health Service. It is also important to note that in addition to cigarette smoking, tobacco is also consumed in other ways by the Bangladeshi community such as paan chewing (chewing tobacco mixed with areca nut rolled in a betel leaf) and shisha smoking (The NHS Information Centre, 2006; Bush et al., 2003; Jayakody et al., 2006) . Paan chewing is particularly prevalent among females (The NHS Information Centre, 2006) and shisha smoking among the younger population (Bush et al., 2003; Jayakody et al., 2006).

Also as discussed earlier the Bangladeshi population is one of the most deprived in the UK with high rates of unemployment amongst adult men and women, lowest mean weekly earnings and lowest rates of home owner-occupation (Modood et al., 1997). Hence they would be considered most at risk from smoking and typically deemed hard-to-reach- by local smoking cessation services. However, there are some promising developments. The use of NHS Stop Smoking Services by ethnic minority groups has been increasing over recent years (The NHS Information Centre, 2009). Unfortunately data according to age and ethnicity is not available but overall figures for setting a quit date for the Bangladeshi population were 1,997 people in 2005/2006, 2650 people in 2006/2007 and 4250 in 2008/09 (The NHS Information Centre, 2009). It is hoped that by conducting further research with the Bangladeshi population, ways to help sustain this increase can be identified.

Somali male and female adolescents will also be included in the study for a number of reasons. National figures show smoking rates to be lower for the Black African population than the general population, with the male rate 21% compared to 24% for the general

population and the female rate 10% compared to 23% for the general population (The NHS Information Centre, 2006). Likewise the figures reported for the youngest age group of 16-34 years also show lower rates with 21% for Black African males compared to 32% for general population males and 15% for Black African females compared to 28% for general population females (The NHS Information Centre, 2006). However, there are currently doubts over the accuracy of national smoking rates for the Somali population because the last National Census in 2001 did not differentiate between different Black African groups but placed them in one category. Black African Somalis do not share any culture, language, diet, dress and religious practices with their near neighbours – all factors which can hugely impact on smoking. Hence the figures may not accurately reflect the true rates (Khan & Jones, 2002). Local surveys which have been conducted since the 2001 Census have broken down the Black African category and found higher rates for the Somali population. For example, a survey conducted by Straus, McEwen and Croker (2006) in a local borough, found a smoking rate of 31% (compared to 25% for the UK general population). Anecdotal reports also purport that a significant number of the Somali population smoke and that this is increasing (Straus et al., 2006). Similar to the Bangladeshi population there are anecdotal reports from studies that the number of young Somalis (under 30 years of age) smoking is increasing, and a further suggestion that women are also starting to take up smoking (Straus et al., 2006). Also studies have found that smoking is more prevalent amongst older Somalis, in contrast to the general population but in common with Bangladeshis (McEwen, Hajek, McRobbie, & West, 2006). Hence the concerns outlined earlier with Bangladeshi male youth emulating the habits of their elders and female youth increasingly taking up smoking can also be applied to the Somali population.

A further area of concern is that whereas uptake of Stop Smoking Services is improving for the Bangladeshi population there is some evidence that first generation black

minority ethnic groups (BMEG) and refugees, such as many of the Somalis in the UK, are particularly vulnerable to low participation in smoking cessation services despite having similar intentions to quit as the UK general population (Crossier & McNeil, 2003; Health Education Authority, 2000). Also the Somali community, like the Bangladeshi community, is one of the most deprived communities in the UK. They have the next highest national deprivation scores following Bangladeshi and Pakistani groups (classed under the Black African category) (Tinsley& Jacobs, 2006). Therefore it can be argued that from a reducing health inequalities perspective, further work to help improve accessibility to cessation services for the Somali population is required, indicating the importance of research with this population.

In addition to smoking tobacco, it is also important to note that a popular form of tobacco use amongst the younger generation and women is shisha pipes (Straus et al., 2006). Shisha pipe use is common in Arab countries where many Somalis in the UK have migrated from. They are used in social settings and it has been discovered that there is a perception that shisha pipes are safe, or safer, than smoking cigarettes (although they are not used on as much of a regular basis) (Straus et al., 2006).

The White British population were included in the study because they are majority ethnic group in the UK and would provide a cultural point of comparison. Also the literature review for the general population highlighted that although there is increasing emergence of qualitative studies, much of the research was quantitative, comprising mainly of correlational data. Authors such as Denscombe (2001), argue the need for further qualitative research. For example, he states that further research exploring young smokers' motives for wanting to stop, and their experiences of the process of trying to give up smoking, is needed. Only by conducting greater qualitative research can further insight into possible relationships between variables and underlying processes at work be revealed.

Overall by having these three cultural groups represented in the study it can be explored if there is a shared cultural experience of smoking or if there are contrasts. It is hoped that such a study could help the local Stop Smoking Service and other services with a similar population, identify strategies that could prevent smoking uptake and aid with cessation for smokers from these groups.

1.11. Title of research

Exploring the process of smoking pre-initiation, initiation, maintenance and cessation for adolescent Somali, Bangladeshi and White British smokers.

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CHAPTER 2

METHODOLOGY

2.1. Method

It was decided to use focus groups for the study. This is because it was felt that the interaction among the young people would help generate a valuable source of data. As Kitzinger (1995) states, the group processes involved in focus groups help participants explore and clarify their views that would be less easily accessible in one-to-one interviews. Furthermore group discussions allow researchers to be alerted to many different forms of communication that people use in everyday interactions such as jokes, anecdotes and teasing which is useful because people's knowledge and attitudes are not fully encompassed in reasoned responses to formal direct questioning (Kitzinger, 1995). As a result it can be argued that data obtained from focus groups has more ecological validity because the setting is less artificial than the one-to-one interview setting (Willig, 2008).

Also although a series of open-ended questions had been prepared, the group discussion could enable the participants to generate their own questions, explore the issues that were important to them and in their own vocabulary, which was felt important given the exploratory nature of the research. In addition, data generated from focus groups is considered more likely to reflect the social and cultural norms of the groups (Holmes, 1998). Again this is beneficial to the study because it would provide insight into whether young people from the different ethnic groups may have social and cultural norms around smoking which could have impacted on their smoking behaviour.

One issue which was considered at length was the suitability of using focus groups with Bangladeshi and Somali female participants, when the issue of female smoking is

considered socially taboo. It was debated whether the sensitive nature of the research should warrant the use of individual interviews as opposed to focus groups. The issue was discussed with youth club leaders who worked with adolescent Somali and Bangladeshi females. They consulted with their Somali and Bangladeshi female members (who were not all smokers) who reported that they would prefer to take part in a group discussion with their friends as opposed to being interviewed alone. This was due to feeling less intimidated being in a group setting with their friends. This was reflected in research discovered on conducting sensitive research. For example, Oliveira (2011) states that focus groups can work well with sensitive research involving teenagers because the degree of intimacy and friendship among the research participants can help to facilitate conversations. Therefore the use of focus groups was deemed suitable.

A semi-structured interview schedule was developed for the focus groups (appendix 1). As grounded theory was to be used during data collection and analysis, it was recognised that from a purist grounded theory perspective, an interview schedule was not necessary or even a few broad open ended questions would be ideal (Charmaz, 2006). However, from a practical point of view, a semi-structured interview schedule was needed to assist with ethical clearance for the study as it had to be detailed enough to convince the ethics panel that no harm would come to the research participants (Charmaz, 2006). Also as Charmaz (2006) states, having an interview guide with well-planned open-ended questions and prepared probes can increase your confidence and allow you to focus on what the participant is saying without worrying about what to ask next and how to phrase it. However, attempts were made to keep the schedule open enough to allow unanticipated material to emerge during the interview. For example, the questions were open-ended and only provided a rough guide for the researcher and participants and the order of the questioning was flexible allowing the participants to discuss the latter questions in the early stages if that was how the discussion

proceeded. It was attempted though to end the discussion with more positive questioning so the discussion finished on a more positive note, which is preferable from an ethical point of view (Charmaz, 2006).

As grounded theory was being used, the interview schedule was revised a number of times allowing it to follow up new leads discovered in the simultaneous ongoing analysis. For example, as the focus groups progressed it was discovered that the participants were talking about their perceptions of non-smokers and so this was added to the interview schedule. This theoretical sampling aided with eventual theoretical saturation.

In the end twelve main questions were left along with prompt questions for each of them (which are provided in brackets). The prompt questions were developed to allow for further exploration of the main questions.

2.2. Participants

Participants were i) Bangladeshi, Somali or White British, ii) aged 16-17 years and iii) born and raised in the United Kingdom (UK). They were all regular smokers which was defined as smoking at least one cigarette a week, which is in accordance with the definition used by the 'Drinking and Drug Use among Young People Survey' (The National Health Service [NHS] Information Centre, 2009). They all resided in a deprived inner city borough, which was discussed in the introduction, where the Stop Smoking Service that the researcher was based in, was located.

It was decided that it would be beneficial for the group discussion if the participants were already acquainted with each other prior to taking part in the focus group. This is because there is more likelihood of them interacting with each other the same way they would interact with their peers outside of the research context (Willig, 2008). Also as

discussed earlier this was deemed preferable for the Somali and Bangladeshi female groups. Also the focus groups were to be segregated by gender so the males were to have separate group discussions to the females. It was felt this would lead to more open and honest discussion, particularly with the Bangladeshi and Somali females, as female smoking is considered more taboo in these communities. As a result the focus groups were 'pre-existing', because the members were already familiar with each other and they were 'concerned' because the subject matter of the focus group discussion concerned the participants' personal circumstances (Willig, 2008).

Participants were recruited via opportunistic and snowball sampling. It was decided to recruit participants from non-teaching establishments. This is because participants may have felt inhibited to discuss their experiences of smoking in a school setting, with the presence of authoritative figures, such as their teachers, around. There was also the risk that they could view the adult researcher in a similar authoritative way, thus impacting on their levels of disclosure. Therefore youth clubs and other community groups which took place out of school hours were approached. These contacts were obtained primarily through the young persons' advisor working at the local Stop Smoking Service and recommendations made by leads working in young peoples' services at the local council.

Incentives were used in the study, which consisted of a pair of cinema tickets. These had been decided upon at the start of the study after consultation with the young persons' worker at the local Stop Smoking Service and recommendations from local youth club workers.

In total six focus groups were conducted before it was felt theoretical saturation had been reached and no further categories were generated. Five to six participants were recruited for each focus group. A maximum of six participants was agreed upon to ensure that all participants remained actively involved in the group discussion throughout the data collection

phase and also because it is very difficult to transcribe data for more than six participants (Willig, 2008).

Background data on the participants' smoking behaviour was collated on a participant record sheet (appendix 2). This included the participant's:

- Name
- Date of Birth
- Gender
- Ethnicity
- Duration of smoking behaviour
- Weekly cigarette consumption
- Number of serious quit attempts
- Longest period quit
- Support accessed to quit smoking
- Other tobacco use

Pseudonyms were used for the participants during the analysis stage for confidentiality reasons.

2.2.1. Bangladeshi males' focus group

Table 2. 1. **Background Data for the Bangladeshi Males**

Participant	**Age**	**No. of Years Smoked**	**No of cigarettes a week**	**No. of serious quit attempts**	**Longest period quit**	**Support to quit**	**Other tobacco use**
Adan	17	8	40	1	2 days	NRT gum, patch	None

Zahir	17	6	50	2	3 weeks	NRT gum	None
Salman	17	2	15	1	1 week	None	Cannabis
Ismail	17	7	35	2	7 days	None	Cannabis
Hasan	17	4	25	2	1 month	NRT gum, inhalator	Cannabis

The Bangladeshi males' focus group consisted of five participants who were all 17 years old. The number of years they had smoked ranged from 2 to 8 years. The number of cigarettes smoked a week ranged from 15 to 50. The number of serious quit attempts ranged from 1-2 times and the longest period quit from 2 days to 1 month. Three of the Bangladeshi males had used Nicotine Replacement Therapy (NRT) products to aid with a quit attempt. Three of the males also smoked cannabis.

2.2.2. Bangladeshi females' focus group

***Table 2.2*. Background Data for the Bangladeshi Females**

Participant	**Age**	**No. of Years Smoked**	**No of cigarettes a week**	**No. of serious quit attempts**	**Longest period quit**	**Support to quit**	**Other tobacco use**
Priya	17	3	40	1	3 weeks	None	Shisha
Mala	16	2	40	1	1 day	None	Shisha
Dipika	17	5	20	1	1 week	None	Shisha Paan Cigars
Bharati	16	4	140	1	3 hours	NRT gum	Shisha Cannabis
Sanchita	17	5	40	2	6 months	Sweets	None
Anjali	16	6	100	3	1 year	NHS support	Shisha

The Bangladeshi females' focus group consisted of six participants, three of whom were 16 years old and three 17 years old. The number of years smoked ranged from 2 to 6 years. The number of cigarettes smoked a week ranged from 20 to 140. The number of serious quit attempts ranged from 1 to 3 and the longest period quit ranged from 3 hours to 1

year. One participant had accessed NHS cessation services, one had tried NRT gum and one used sweets to help her stop smoking. Five participants also used shisha as additional tobacco use, one used cannabis, one used paan and one used cigars.

2.2.3. Somali males' focus group

***Table 2.3*. Background Data for the Somali Males**

Participant	Age	No. of Years Smoked	No of cigarettes a week	No. of serious quit attempts	Longest period quit	Support to quit	Other tobacco use
Abdi	17	3	20	6	2 weeks	None	None
Dalmar	17	5	70	2	2 weeks	None	Shisha
Roble	17	4	30	3	2 months	None	None
Taban	17	1	40	3	1 week	None	None
Ghedi	17	2	40	2	1 month	None	Shisha
Erasto	17	8	70	3	3 months	None	None

The Somali males' focus group consisted of six participants who were all 17 years old. The number of years smoked ranged from 1 to 8 years. The number of cigarettes smoked a week ranged from 20 to 70. The number of serious quit attempts ranged from 2 to 6 and the longest period quit ranged from 1 week to 3 months. None of the Somali boys had accessed support to quit and two of them also smoked shisha.

2.2.4. Somali females' focus group

***Table 2.4*. Background Data for the Somali Females**

Participant	Age	No. of Years Smoked	No of cigarettes a week	No. of serious quit attempts	Longest period quit	Support to quit	Other tobacco use
Ayan	16	2	60	2	1 day	NRT patches	None
Nadifa	17	6	140	1	1 day	None	Shisha
Xaali	16	2	70	0	N/A	N/A	None

Amina	16	3	70	2	2 months	None	None
Deeqa	17	1	3	2	2 months	None	Shisha
Hawiiya	17	3	70	2	3 months	None	None

The Somali females' focus group consisted of six participants, three who were 16 years old and three 17 years old. The number of years smoked ranged from 1 to 6 years. The number of cigarettes smoked a week ranged from 3 to 140. The number of serious quit attempts ranged from 0 to 2 and the longest period quit from 1 day to 3 months. Only one participant had accessed support to stop in the form of NRT patches. Two participants also used shisha.

2.2.5. White British males' focus group

***Table 2.5*. Background Data for the White British Males**

Participant	**Age**	**No. of Years Smoked**	**No of cigarettes a week**	**No. of serious quit attempts**	**Longest period quit**	**Support to quit**	**Other tobacco use**
Jack	17	6	140	3	3 weeks	NRT gum	Cannabis
David	17	3	100	1	1 week	None	Cannabis
Sean	17	5	120	3	1 month	NRT gum	Cannabis Shisha
Liam	16	3	120	2	4 days	None	Cannabis
Robert	17	4	140	3	1 week	NRT gum	Cannabis

The White British males' focus group consisted of five participants, four of whom were 17 years old and one 16 years old. The number of years smoked ranged from 3 to 6 years. The number of cigarettes smoked a week ranged from 100 to 140. The number of serious quit attempts ranged from 1 to 3 and the longest period quit ranged from 4 days to 1 month. Three of the White British males had used NRT gum to quit. All five participants smoked cannabis and one also smoked shisha.

2.2.6. White British females' focus group

***Table 2.6*. Background Data for the White British Females**

Participant	Age	No. of Years Smoked	No of cigarettes a week	No. of serious quit attempts	Longest period quit	Support to quit	Other tobacco use
Tina	17	4	10	3	2 weeks	None	Shisha
Melanie	16	4	15	2	3 months	NRT inhalator	Shisha
Claire	16	4	10	1	1 week	NRT patches, inhalator	None
Vicky	16	3	5	5	4 months	NRT gum	None
Lisa	16	3	30	2	2 months	None	None

The White British females' focus group consisted of five participants, four of whom were 16 years old and one 17 years old. The number of years smoked ranged from 3 to 4 years. The number of cigarettes smoked a week ranged from 5 to 30. The number of serious quit attempts ranged from 1 to 5 and the longest period quit ranged from 1 week to 4 months. Three of the participants had used NRT products to help them quit smoking. Two participants smoked shisha.

2.3. Procedure

Initially contact was made with the gatekeeper of the establishment. Once the gatekeeper was informed about the study and agreed to assist he or she would mention the research to the young people to identify potential recruits. All gatekeepers were sent participant information sheets (appendix 3) which contained detailed information of the study and the participant's expected role in the study, along with participant consent forms (appendix 4) which all young people wishing to take part had to complete. Although the gatekeepers acted as mediators they did not coerce the young people to participate in the

study in any way. This was done by discussing the purpose of the study but reiterating that participation was completely voluntary and that there was no pressure to participate.

The researcher then arranged to have a further information session with the potential participants who had expressed an interest to answer any further queries and complete any outstanding consent forms, before a date for the focus group was arranged. This gave the participants sufficient time to consider their involvement in the study. The researcher also arranged to get all the mobile phone numbers of the potential participants with their consent because the gatekeepers mentioned that they could be quite unreliable for turning up at events. Therefore regular reminders were sent and contact made with the young people in the lead up to the focus group to ensure attendance.

The group discussion took place in a private room which had been organised by the gatekeepers on the premises. As some of the young people could be quite disruptive in their behaviour, arrangements had been made prior to the discussion for a staff member of the youth club to pop into the room regularly to check everything was alright. It was agreed that this would be done very discretely with minimal disruption to the focus group. The focus group was seated in a circular formation to encourage discussion (Kleiber, 2004).

The discussion following the interview schedule took place for a maximum of an hour and was audio taped on a digital Dictaphone with a separate cassette Dictaphone used as a backup. At the start all participants were requested to introduce themselves and state their ages to help with identification of voices later when transcribing. A quick check was also made to ensure that the Dictaphones were recording. All participants were reminded again that they were free to withdraw from the study at any point. During the discussion the researcher steered the discussion, which involved ensuring the discussion stayed on topic, getting participants to react and respond to others' opinions and encouraging maximum participation from all participants.

At the end of the discussion, questions which had arisen during the discussion but which were not suitable to address at the time were answered, for example, detailed information on national smoking statistics, was provided. Also participants who had expressed a desire to quit smoking during the course of the discussion were provided with leaflets and details of the local NHS Stop Smoking Service. General leaflets on smoking were also made available to all participants. The incentive of two free cinema tickets was also distributed to the participants at the end of the discussion.

Once a focus group discussion was completed, it was transcribed and analysed line by line using grounded theory (see appendix 5 for example transcript). As categories began to develop further data collection was conducted in light of these categories. During the latter stages this theoretical sampling consisted of more specific lines of questioning which occurred for the purposes of eventual theoretical saturation.

2.4. Ethical considerations

The research proposal was approved by the City University Ethics Committee. It was investigated whether the research would also need to be approved by the local NHS Research Ethics Committee because the researcher worked for the NHS. However, the local NHS Research Ethics Committee said this would not be necessary because the research did not involve recruiting participants who were accessing NHS services.

As the young people were aged 16 or 17 years and hence under 18 years of age the issue of informed consent was considered carefully. The British Psychological Society's (BPS) guide on 'ethical principles on conducting research with human participants' (The BPS, 2009), recommends that parental or loco parentis consent be obtained for participants aged under 16 years. Therefore parental or loco parentis consent was not required for the

participants in this study. Instead because accessing the young people also involved passing a gatekeeper of the establishment first (who was an authority figure in charge of the young people) and getting their consent prior to getting the participant's consent, it was felt that this was appropriate informed consent. All gatekeepers were provided with full details of the study and once they consented to the study then potential participants were approached. It was made clear to the potential participants that the researcher was not directly related to the establishment they had been recruited from so they did not assume a similar level of authority to the other adults working at the establishment.

All participants were debriefed on the study by being provided with a participant information sheet which outlined full details of the study and what they were expected to do in the study. Efforts were made to ensure the language, content and design were user friendly for a young audience. The information sheet also contained a consent form which all participants were required to sign prior to taking part in the study. This form expressed the participant's consent over a number of issues, for example, having sufficient time to take part in the study and understanding that participation was voluntary and he/she could withdraw at any time. They were also provided with the option of being given a summary sheet of the findings of the research once the study had been completed.

Confidentiality was assured throughout for the participants. Many of them had concerns over other people, particularly their parents, finding out about their smoking behaviour. They were reassured that although the discussion would be audio-taped only the researcher and researcher's supervisor would have access to it. All tape recordings when not in use were locked away and any identifiers were removed from transcripts. The discussions were conducted in a private room where privacy was ensured.

Consideration was also given to the potential sensitivity of the topic under study. For example, it was understood that some of them may have had a fear of being judged about

their smoking behaviour or may have felt concerned that they would be expected to stop smoking. Therefore the researcher aimed to remain as empathetic and non-judgmental as possible throughout the discussion to try to allay these concerns. If at any stage the participants did feel uncomfortable during the focus group discussion they would be given the opportunity to withdraw. Also at the end of the study although a factsheet on smoking was distributed to all participants, information on stop smoking support services available was not. It was only offered to those who requested it. The aim was to be respectful of the young peoples' decision to smoke and hence to only provide this information if it was requested.

Ethical considerations were also given to the use of incentives in the study, which were a pair of cinema tickets. It was not felt that the use of incentives would increase risk of harm to participants beyond that which they experience in their everyday life without the use of the incentives, which is in line with ethical principles of The British Psychological Society (2009). A decision was also made not to offer direct cash incentives to the young people because they could be used to purchase illegal substances such as cigarettes, drugs or alcohol. Also it was made clear to participants that their receipt of incentives would not be affected by their right to withdraw from the study at any time, as recommended by The British Psychological Society (2009).

2.5. Use of Grounded Theory

Grounded theory was used for analysis. This is because the aim was to try and map and unfold the social processes that occur when a young person, initiates, maintains and tries to stop smoking as opposed to focusing exclusively on the participant's perspective minus its social context, causes or consequences (Willig, 2008). The epistemological approach taken

to grounded theory for this research was the social constructionist approach. Hence it is recognised that the use of grounded theory from this perspective will not capture the social reality but is in itself a social construction of reality (Charmaz, 1990). By taking the social constructionist perspective instead of advocating the positivist belief that theory is discovered by emerging from the data (Glaser,1999) it is believed that theory is constructed by the researcher through an interaction with the data. As Charmaz (2006) states:

> I assume that neither data not theories are discovered. Rather we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives and research practices.
>
> Charmaz (2006, p. 10)

Hence it is acknowledged that researchers' backgrounds (personal, philosophical, theoretical, and methodological), the decisions they make and the questions they ask about the data, inform the research process and fundamentally the findings. As a result it is believed the theory produced offers one interpretation of the data as opposed to the only truth about the data (Willig, 2008). Therefore instead of stating that categories and theory are emerging from the data the lead will be taken by Pidgeon and Henwood (1997) who prefer the notion of theory generation.

The full version of grounded theory was used for this research. Initially a transcript for a focus group was openly coded line-by-line which involved providing descriptive labels to the text (see appendix 6 for example). It was decided to use line-by-line analysis to ensure the analysis was truly grounded so that later theoretical formations were actually generated from the data rather than being imposed on it (Willig, 2008).

Low level categories of abstraction were then identified by grouping the descriptive labels (see appendix 7 for examples). For example, references to 'head rush' and 'nausea' after having a first cigarette were grouped under the category of 'physical effects of first

cigarette'. 'In vivo' category labels were often used which encapsulated words and phrases used by participants in the focus groups. For example, a participant described smoking as a 'socialising mechanism', which was constructed as a category. This helped to ensure the categories were being generated from the data as opposed to from existing theoretical concepts (Willig, 2008).

During the initial coding process the following questions were continually being asked: i) What is happening? (Glaser, 1978), ii) What is this data a study of? (Glaser, 1978), iii) What does the data suggest? (Charmaz, 2006), iv) From whose point of view? (Charmaz, 2006), v) What theoretical category does this specific datum indicate? (Glaser, 1978). Asking these questions continually helped to get maximum abstraction of labels and categories from the data. Also a process of constant comparison was conducted which involved moving back and forth between categories identifying similarities and differences (Willig, 2008). This process led to the development of subcategories within the categories. For example a low level category of 'obtaining cigarettes,' consisting of labels such as, 'asking strangers', 'asking elder family members' and 'purchasing cigarettes' was later split into two sub categories of 'reliance on self' and 'reliance on others' for obtaining cigarettes. Engaging in constant comparison helped to ensure all occurrences of variation were captured within the theory being created (Willig, 2008).

The next step was to link and merge the low-level descriptive categories into higher level abstract ones which involved becoming more analytic as opposed to descriptive. This was done through theoretical coding. The aim was to arrange the categories in a more meaningful and hierarchical way by having some categories constituting as the core and others as the periphery main themes (Willig, 2008) (see appendix 8 for example).

Once this stage of analysis had been completed for a transcript, theoretical sampling was conducted by carrying out another focus group to collect further data in light of the

categories which had just been constructed. The aim was to explore how the developing theory could be expanded or challenged in any way (Willig, 2008). For example, one of the main themes for the experimentation phase of smoking; 'facilitators to initiation,' was later expanded and revised into the main themes of 'opportunity' and 'normalisation,' as further data was obtained. This process of data analysis and collection continued until theoretical saturation was thought to have been achieved whereby no new categories or no further difference within the categories was being readily identified.

Throughout the process of data collection and analysis, memos were also written. These memos helped to record the whole process of theory generation (Willig, 2008) (see appendix 9 for an example of a memo providing definitions of a category and explanations for the labels chosen).

2.6 Reflexivity

Throughout the research process I was aware of myself as an Indian, female researcher and considered the impact of this on the research process. Given that I also took a social constructionist approach to the grounded theory I was conscious of how my own personal, philosophical, theoretical and methodological background and biases could potentially affect the data being collected and my interpretation of it (Willig, 2008).

With regards to the data being collected, I was aware, for example, how my age, gender and ethnicity would be received by the young participants and possibly affect the rapport we were able to build and hence the nature of the data that was collected. As a result whenever I met with the young people I made an effort to try and fit into their world as much as possible to try and break down as many potential barriers, for example by dressing casually and not in my formal work attire and being more casual in my speech. This was to

try and eliminate the perception of me as an authoritative figure in the eyes of the participants.

I felt that on initial meeting with the Somali and Bangladeshi females my ethnicity and outward physical appearance was advantageous. I felt they were less threatened and more at ease when they saw that I was a young black and minority ethnic (BME) female, similar to them. This was supported through the focus group discussion when they made cultural references to the differences between 'white' culture and their own culture. They included me in their collective use of the words 'we' and 'our' when describing the differences between their own culture and white culture thus indicating they felt I shared this understanding and empathy for their experiences. Interestingly it was only the Bangladeshi and Somali groups (both males and females) that asked about my ethnic origin, possibly because there is greater curiosity when also coming from a BME group or just greater social acceptability of the question. I felt it was beneficial that I did not share the same ethnic origin as them because it afforded some distance between us, hence I was close enough to have a shared experience of living as a BME person in England but not close enough to pose a threat over confidentiality, for example to increase concerns over friends, family and community members finding out about their participation in the study.

However, with the White British female participants there was a point when my ethnicity posed a potential disadvantage. There was some racial tension between the local Bangladeshi and White British youth in the area when I was developing the White British females' focus group. The youth club leader warned me that as my study included Bangladeshi youth and I outwardly appeared Bangladeshi there was the possibility this may affect my rapport with the White British females and how they contributed to the focus group. Although I was nervous before meeting them for the first time I was keen to try and behave in the same way with the White British females as I did with the other young

participants. Fortunately I was able to develop a good rapport with the White British females and my initial fears were unfounded. In fact they appeared more concerned about my knowing my age as opposed to my ethnicity.

The only time I felt that my age was a barrier was when I had trouble understanding some of the youth slang used. The lingo used by the young people was common across the different ethnic groups. I had to ask for clarification of certain terms during the interview which appeared to amuse the participants. Otherwise because I appeared younger than I actually am to them (which was evidenced by their guesses that I was only a few years older than them and disbelief when I did reveal my true age) and am used to interacting with adolescents I did not feel it was a hindrance.

Surprisingly the one thing that I had not anticipated being an issue but was raised by the participants was my social status as revealed by my accent. The Bangladeshi and Somali females particularly picked up on the fact that I 'talked posh' and that I must live in a different area to them because we did not 'sound the same'. Again I did not want my accent to have a negative effect on how comfortable and inhibited the participants felt in my presence. I did not want them to feel that I was judging them in any way or looking down on them. Hence I tried to build rapport and put them at ease through engaging in banter and using humour.

One issue I was concerned with at the beginning was how to cope with potential disruptive behaviour from the participants within my role as a researcher (as I was warned about this by the gatekeepers). I was reluctant to have to become a disciplinarian within my role as a researcher as I felt this would jeopardise my relationship with the participants and potentially alienate them from the focus group discussion. As a result it was arranged to have the gatekeepers regularly keeping an eye on proceedings. It is of course part of the researcher's role to steer the focus group to ensure it stays on topic but I did find this a

complex task to manage at times because I wanted to keep the participants engaged and avoid doing anything that may jeopardise this. However, at the same time I was aware I only had limited time to get quality data so had to push myself out of my comfort zone. I felt managing the focus groups with young people who could have 'challenging behaviours' was very different and a lot more complex than my previous experience of conducting focus groups working with adults. This is because they were not so confined by social etiquette and the 'right way to behave'. For example they were more easily distracted and I often had to work at keeping their attention. Unfortunately the setting of the focus groups in the youth clubs made this difficult at times because although the rooms were private sometimes other children would come in and try to disrupt their peers who were participating in the study (which the gatekeepers had to swiftly come in and deal with). However, without setting the focus groups in these locations which were known and familiar to the participants, it was unlikely they would have participated.

I also had to deal with questions from the young people which were not appropriate for me to answer during the course of the focus group discussion or not appropriate to answer at all (often relating to my private life). I often felt that the participants who were asking inappropriate questions about my private life were aware they were not appropriate questions but were just testing the boundaries with me. I dealt with them by saying the questions were not relevant to the study and brushed them off in a light-hearted and friendly manner.

Another thing I attempted to do was encourage active participation from all participants in the focus group. I did find at times some participants would take the lead and domineer so I would aim my questions specifically at the quieter participants through my gaze or use of their name to get them to participate. One of the major challenges was trying to do so many things at one time, for example, being mindful of quiet participants and trying to monitor the discussion by following up interesting points and prompting for more

information. Also at times the discussion got quite heated, often when one participant had views very different to the other members and so I had to step in to diffuse the situation. I was always aware of maintaining an ethical and reasonable environment for all participants.

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Appendices

Appendix 1

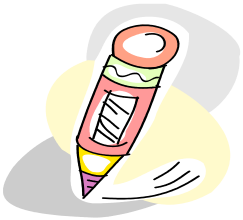
City University London
The University for business and the professions

Interview Schedule

1. What were your views/thoughts on smoking growing up? (Were you aware of any smokers? What did you think of smokers?)
2. What were your views/thoughts on smoking before you had your first cigarette? (Talk about the lead up to your first time smoking)
3. Tell me about the first time you had a cigarette (Why did you start smoking? Who were you with? Where did you get the cigarettes? How did you feel after the first cigarette? What were your first experiences of seeing or touching a cigarette?)
4. Talk about what happened after the first time you smoked (What were your thoughts on having another cigarette)
5. Why did you continue to smoke? Why do you smoke? (What was the lead up of events that made you smoke again? At what times of the day, situations will you smoke? How do you feel when you smoke?)
6. How do you view your own smoking behaviour? (How much is it part of you? In regards to its impact on others? Smoking in today's society?)
7. How do others view your smoking behaviour? (What level of awareness is there of your smoking amongst friends/family/ wider society? Their reactions to your smoking?)
8. How do you view non-smokers? (E.g. your peers, family, strangers etc?)
9. Talk about your experiences of getting cigarettes (Where do you get your cigarettes from?)
10. What are your thoughts on stopping smoking? (Ease of stopping? Ways of stopping? Most effective ways of stopping? Outcomes of stopping? Reasons for stopping – why do you think people stop? Experiences of others around you trying to stop?)
11. If you have tried to stop, what were your experiences (How did you feel when you tried to stop smoking? How did others around you react?)
12. What are you views on your smoking behaviour long-term/next 10 years/next 50 years? (How do you see your quit status? How do you view your health/self?)

Appendix 2

City University London
The University for business and the professions



No:…….

Participant Record Sheet

1) Name:……

2) Date of Birth:……(dd/mm/yyyy)

3) Gender: Male ☐ Female ☐

4) Ethnicity: Bangladeshi ☐ Somali ☐ White British ☐

5) How long have you smoked for? (number of years, months, etc)……

6) How many cigarettes do you smoke per week? ……

7a) Have many times have you seriously tried to stop smoking? ……

7b) If you have tried to stop smoking what was the longest time you managed to stop smoking for? ……

7c) If you have tried to stop smoking did you get any help? (Nicotine Replacement Therapy products, support from a Doctor/Pharmacist, etc)

……

8) Apart from smoking cigarettes do you use tobacco in other ways (e.g. paan chewing, shisha, bidis, snuff)

Yes ☐ (please state in which way(s)) …… No ☐

Thank you!

Appendix 3

City University London
The University for business and the professions

Participant Information Sheet

Study Title: Exploring the process of smoking pre-initiation, initiation, maintenance and cessation for adolescent Somali, Bangladeshi and White British smokers

You are being invited to take part in a study exploring how and why young people aged 16-17 years old from Bangladeshi, Somali and White British backgrounds start smoking cigarettes, maintain their smoking and try to stop smoking.

Before you decide whether you would like to part, it is important that you understand why this study is being carried out and what it will involve. Please take time to read the following information and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this

What is the purpose of the study?

Cigarette smoking amongst Bangladeshi and Somali adult males is amongst the highest in England and there are concerns that young Bangladeshi and Somali males are following this behaviour. Although cigarette smoking among adult Bangladeshi and Somali females is less common there are reports that it is increasing among young females. To help reduce cigarette smoking among young people we need to understand more about their smoking, which is what this study will help to do.

Why have I been asked to take part?

You have been asked to take part because you are a 16-17 year old Bangladeshi, Somali or White British smoker who regularly smokes 1 or more cigarettes a week. You will also have been born and educated in the UK.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part please sign and return the enclosed consent form. The information sheet is yours to keep. Please note that once you have signed the consent form you may still withdraw from the study at any time without giving a reason.

What will happen to me if I take part?

You will take part in a focus group interview, which will involve you talking about your experiences of smoking, in a group of up to 5 other people from the same ethnic and

gender group as you. The interview will last for up to an hour and will take place in a confidential and private location. The interview will be recorded on a Dictaphone, written up and stored securely on a computer system. It will be then be analysed.

When the research has been completed and analysed we will let you know the findings in a written summary sheet.

What happens to the information?

The information that you give us is **strictly confidential** and only the research team will have access to it. If any articles are published on the study they will not contain your name or any other identifiable information.

What are the possible benefits of taking part?

Talking about your experiences of smoking along with hearing other people's experiences may be beneficial in helping you gain further insight into your smoking habit.

Also you will be provided with a pair of cinema tickets, which will be distributed on successful completion of the interview.

What happens when the study stops?

The researcher will write up the results from the study as part of an educational programme.

Results will also be published in educational journals. A summary of the results will be available to you.

What if I am unhappy with the research?

If you have any concerns about any aspect of the way you have been approached or treated during the course of the research, the research team will be very happy to discuss this with you. They will also be happy to explain the study further if you have questions not answered by this sheet. The lead researcher's contact details are provided on the sheet below.

Who has reviewed the study?

This study has been reviewed by City University Research Ethics Committee.

Any questions or comments?

If you want any more information or have any comments about this study please contact: Riba Kalhar, Health Psychologist in Training, [redacted], riba.kalhar@[redacted].nhs.uk

Thank you for considering taking part and taking the time to read this sheet.

Appendix 4

Participant Consent Form

Study Title: Exploring the process of smoking pre-initiation, initiation, maintenance and cessation for adolescent Somali, Bangladeshi and White British smokers

There is no need to sign or return anything if you do not want to take part.

Please tick all boxes

I confirm that I have read and understood the information sheet for the above study, been given a copy to keep and have had the opportunity to ask questions.

☐ I am willing for a researcher to contact me in the future to ask if I would like to help with further smoking-related research.

☐ I confirm that I have sufficient time to take part in this study.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without any future support or legal rights being affected.

☐ I understand that personal information given by me will be recorded by the researcher and held on a secure computer database.

_____ _____ _____

Name of Client Signature Date

Address: _____

_____

_____

_____ _____ _____

Name of Person taking consent Signature Date

If you would like a summary sheet of the findings of this research once the study is completed

Please tick the box ☐

Thank you for your participation.

Appendix 5

Example transcript (Bangladeshi female group)

Priya: They're like 'why why why'?! I go and sit down in the morning, and it's not even a 'hello' from them 'but you smell of cigarettes!'

I: Really?

Priya: I say get over it! (laughs)

I: How does that make you feel?

Priya: In a way it's like like because I'm so used to it, and like a lot of my secondary friends, I spent all, they spent half my five years of my life like just telling me why why why, you know kind of thing? And it's like just let me do it, and they might, even my close friends have realised not to kind of bug me too much. Yea they just leave it cos they...

Dipika: They give up in the end (all laugh)

Priya: Yea I think they realise to a certain point where, ok it's going in one ear and out the other and she's clever enough to know when to stop kind of thing. And they kind of get that so obviously it's different from my secondary friends so they've known me all my life so they, with my college friends they haven't known me for long so obviously they're still in the process of like you know why are you doing it? Why are you doing it?

I: Ok yea.

Priya: And you know they just, it's not that they don't understand cos totally, if I didn't smoke and my friends smoke I'd probably do the same thing as well, like 'you know you shouldn't do it' de de de but

I: Alright

Dipika: I don't care what they do (laughs), they're friends aren't they.

Mala: I was like whoa if you wana smoke, smoke.

Appendix 6

Line-by-line descriptive labels to text (Bangladeshi female group)

440-441: Negative reaction of non-smokers in peer group - smell of cigarettes

443: Ignoring non-smoking friends' protestations – dismissive - get over it

445: Used to non-smoking friends protestations

446: Time period of experiencing non-smoking friends' protestations – peers questioning smoking behaviour – why?

447: Asking for acceptance from non-smoking friends - just let me do it

447-448: Reaction of secondary school friends - Realisation of close secondary school friends to leave it alone and let her smoke

447-448: Realisation of close secondary school friends that their advice is not being heeded

452-453: Difference in reaction between secondary school friends and college friends - college non-smoking friends still in process of questioning smoking behaviour – as new friendship

456: Not lack of understanding in non-smoking peers

456-458: Empathy - understanding of non-smoking peers' negative reaction to smoking - would do the same thing if roles were reversed

460: Lack of concern over friends' behaviour

461: Acceptance of smoking friends' smoking behaviour

462-464: Attitude towards interference of non-smoking peers - Understanding that smoking is a personal choice but feels you care about a person when you question them over it

Appendix 7

Examples of low level categories for initiation stage – Bangladeshi male focus group

A.OBTAINING CIGARETTES

Asking elder family members

Got older people to buy their cigarettes: 153-154, 156, 161

Asking strangers

Used to approach strangers on the street to buy him cigarettes: 163-164

Purchasing from shops

Used to get served in shops even when younger: 157, 158

B.SETTING FOR INITIATION

Location

Location of first cigarette in school toilets: 87

Did not start smoking when in school: 254

Presence of others

Friends present during smoking initiation: 85

C. PHYSICAL EFFECTS OF FIRST CIGARETTE

Head rush

Head rush after first cigarette: 95, 96, 81

Got a head rush when first started but stayed awake for game: 574

Nausea

Feeling sick after first cigarette: 98, 99

Vomiting after first cigarette: 101

Appendix 8

Example of higher level category formation for experimentation phase of initiation – Bangladeshi male focus group

CORE CATEGORY

Construction of the smoking world

MAIN THEME	**MAIN THEME**	**MAIN THEME**
Drive for initiation world	**Facilitators to initiation**	**Entering smoking**
	-Prior exposure to others' smoking	-Physical effects of first cigarette
	-Location	-Engaging in smoking technique
	-Presence of smokers	
	-Obtaining cigarettes	

Appendix 9

Category: Physical effects of initiation (Somali female group)

Initial coding	Label	Explanation for label
Choking Started choking when first smoked: 142-143 **Head rush/Dizziness** Head rush: 76 Got a head rush after first cigarette: 150 Felt really dizzy after first cigarette: 148 Head kind of hurting: 76 Got a headache when first smoked: 139 **Coughing** First pull on cigarette you cough: 302-304 Started coughing when first smoked: 143 Every time I would inhale I would start coughing: 50 After inhaled the cigarette coughed for a while: 133, 137	Physical effects	Involves physical changes that take place in the body when smoke a cigarette for the first time
Change from bad to good -got head rush, head kinda hurt and then it felt kinda good: 76-77 -Got a headache and then felt relaxed afterwards: 139	Change from negative to positive effects	Involves experiencing a change from negative to positive effects felt on the body
Feeling good: Felt kinda good, felt nice, was fun to do: 76-77 **Liking effects** -I felt that I liked it so then I thought ok after that it makes you feel good: 118-120	Positive response towards physical effects	Consists of positive attitudes and feelings towards the physical effects experienced on the body
Feeling disgusting Smoking felt disgusting when first smoked: 142 **Tasted nasty** Cigarette tasted nasty in the beginning: 138	Negative response towards physical effects	Consists of negative attitudes and feelings towards the physical effects experienced on the body

CHAPTER 3

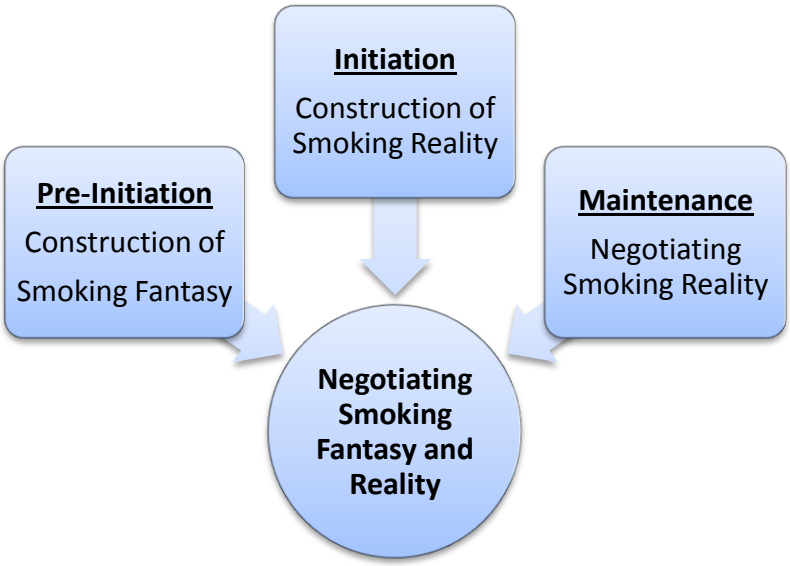
RESULTS

3.1. Overview of core categories

The results will be presented in three different sections with each section identifying each stage of the smoking journey for the participants. This consists of the pre-initiation stage, the initiation stage and the maintenance stage. The experience of cessation for participants is reflected in the maintenance stage.

The figure below highlights the core categories for each of these three stages along with the combined core category for all three stages:

Figure 3.1. **Individual and Combined Core Categories for the Pre-Initiation, Initiation and Maintenance Stage**



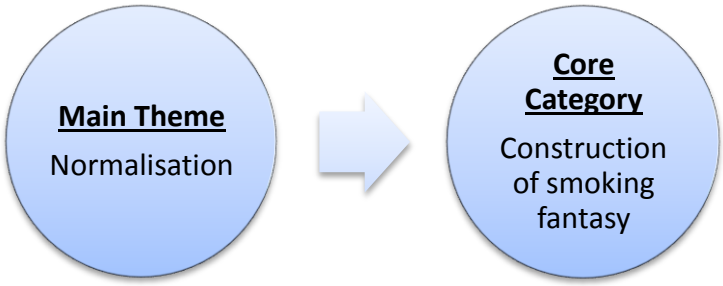
It can be seen that the core category for the pre-initiation stage is ‘construction of smoking fantasy’, for the initiation stage is ‘construction of smoking reality’ and for the

maintenance stage is ‘negotiating smoking reality’. The over-arching core category for all three stages is ‘negotiating smoking fantasy and reality’. The individual core categories for each of the three stages will now be discussed in turn.

3.2. Pre-Initiation: Construction of smoking fantasy

The core category for the pre-initiation stage is ‘construction of smoking fantasy’, which comprises of the main theme of ‘normalisation’, as indicated in the figure below:

Figure 3.2. **Core Category and Main Theme for the Pre-Initiation Stage**



The main theme of normalisation will now be discussed, with a summary of how it relates to the core category, provided at the end.

3.2.1. Normalisation

All of the focus groups indicated normalisation of smoking in the pre-initiation stage, with smoking being represented as the norm or as deviant from the norm.

3.2.1.1. Smoking as the norm

Smoking as the norm was expressed by the all of the groups and was highlighted through childhood exposure to smoking and childhood acceptance of the smoking world.

3.2.1.1.1. Childhood exposure to smoking

Childhood exposure to others' smoking comprised of exposure to familial smoking and peer smoking when growing up.

All of the groups described exposure to familial smoking during childhood, which involved one or more close family members smoking. The Somali and Bangladeshi female groups commented on a high frequency of exposure and the Bangladeshi female group also discussed exposure to gender differences in familial smoking, which led to the development of gender smoking norms. For example, Priya from the Bangladeshi female group described how she originally thought smoking was a male activity, due to high childhood exposure to male smoking, but how this view changed when being exposed to covert smoking practices of female family members:

> Priya: Because it was only men that were around me smoking, I mean later on I did find out that my Nan smokes because I literally was staying at my Nan's house and I woke up and I see a cigarette in her mouth and I was like surprised, thought 'okaaay' and went back to sleep.
>
> [Others laugh]
>
> Priya: You know.
>
> Dipika: It was just a dream!
>
> Priya:...umm yea but when I was younger because I only saw men smoking I honestly thought smoking was for boy.
>
> Dipika: Man thing.
>
> Priya: Yea it's a man thing you know, I thought ok that's why you know smoking is for boys because they're stronger and they're cool you know.
>
> (Bangladeshi female group: pg. 61-62/ lines 1403-1417)

Exploring the Process of Smoking

Exposure to covert smoking practices were discussed by the Bangladeshi female group for female members of the family and also younger family members and these practices were described as stemming from traditional smoking and age gender norms:

> "No what she [grandmother] used to do, it's really funny. She used to go to the spare room and open the bathroom window and she just used to take quick pulls... I think cos she's a woman as well. In like the family she obviously doesn't want to expose something like that, it's seen as bad for a lady. Smoking is not very ladylike is it?"
>
> (Anjali, Bangladeshi female group: pg. 60-62/ lines 1386-1424)

The Bangladeshi female group also spoke about exposure to familial members' refusal to quit smoking, which was in response to own and other's encouragement for cessation and finally the Bangladeshi male group described childhood exposure to passive smoking, from family members and also the wider community:

> Hasan: I was passive smoking before I was smoking when I was a kid.
>
> Adan: Was you?
>
> Hasan: Yea.
>
> Adan: Really?
>
> Zahir: I was as well.
>
> Salam: I've been passive smoking. Everyone passive smokes man when people around you are smoking.
>
> (Bangladeshi male group: pg. 24-25/ lines 616-622)

Next, childhood exposure to peer smoking was mentioned by the Somali male and Bangladeshi female group, which involved being exposed to peer smoking at school:

> "I went outside cos everyday at school I used to see people smoking. I used to play football every time, every single day, morning to night and sometimes after school and there's a corner. Just around the corner from my football pitch, which is right there and opposite the football pitch is the smoker crowd and say you're about to score a goal and every time you score a goal you see either a boy or a girl smoke." (Erasto, Somali male group: pg. 9/ lines 223-227)

Overall as a result of being exposed to familial and peer smoking in childhood, smoking behaviour as a 'norm' was being relayed back to the participants in the pre-initiation stage of smoking and recognition of the existence of a smoking world was being developed.

3.2.1.1.2. Childhood acceptance of the smoking world

All of the groups apart from the Bangladeshi male group expressed an acceptance of the smoking world during childhood. This was demonstrated through a psychological and physiological acceptance of the smoking world.

Psychological acceptance of the smoking world firstly involved having positive feelings towards familial smoking, such as feelings of wonderment and curiosity towards the smoking behaviour, which led to intentions to smoke:

> "Umm my Nan smokes...And me and my cousin brother we were actually so amazed when we saw her, we were like 'wow lets smoke'." (Priya, Bangladeshi female group: pg. 3/ lines 84-87)

It also included having positive attitudes which involved being unfazed by family members' smoking and their smoking paraphernalia, due to a process of desensitisation.

> "I've touched cigarettes before when I was younger because I used to find cigarettes in my uncle's pockets. I just got used to seeing them. Like it didn't really bother me, cigarettes wasn't like a big thing for me." (Anjali, Bangladeshi female group: pg. 10/ lines 239-241)

Finally, it involved behavioural acceptance of peer and familial smoking which comprised of partaking in peer and familial smoking rituals, emulating familial smoking behaviour and showcasing cigarettes to peers. For example:

> Tina: Like when my mum would come inside from work and give me one. I had held a cigarette before but not lit it.
>
> I: Oh right, ok because you used to do it for your mum?
>
> Tina: Yea.
>
> I: Ok right.
>
> Tina: I never used to smoke it though.
>
> I: No?
>
> Tina: She asked me to give her one and then she'd just light it.
>
> Claire: Yea I did that for my dad cos my dad smokes but my mum don't smoke.
>
> (White British female group; pg. 3-4/ lines 53-61)

Next, physiological acceptance was indicated by Anjali from the Bangladeshi female group, who spoke about increased tolerance to properties of smoking, as a result of exposure to her uncle's smoking:

> "I used to hate the smell but then I got used to it because I spent so much time with my uncle." (Anjali, Bangladeshi female group: pg. 60/ lines1375-1376)

Overall this psychological and physiological acceptance of the smoking world in childhood indicated how smoking was becoming accepted as a normal behaviour by participants in the pre-initiation stage of smoking.

3.2.1.2. Smoking as deviant from the norm

Smoking being deviant from norm was also expressed by all of the groups and was highlighted through childhood exposure to non-smoking and childhood rejection of the smoking world, which will be discussed in turn.

3.2.1.2.1. Childhood exposure to non-smoking

Childhood exposure to non-smoking comprised of exposure to complete familial non-smoking. Participants from both of the Somali groups mentioned growing up in complete non-smoking households, for example, the male group stated:

> "Like obviously growing up in a household like mine my dad was very strict, so any form of smoking was not allowed in the house." (Ghedi, Somali male group: pg. 5/ lines 138-139).

As a result of not being exposed to smoking behaviour within the family, smoking was not considered the norm for these participants during childhood.

3.2.1.2.2. Childhood rejection of the smoking world

All of the groups expressed rejection of the smoking world in childhood. This was demonstrated through negative attitudes towards smoking and lack of intentions to smoke.

Negative attitudes towards smoking included i) having negative attitudes towards smokers ii) having negative attitude towards effects of smoking (e.g. smell, health risks and

perceived negative taste) iii) having disapproval and showing encouragement for cessation for familial smoking, which was only mentioned by the Bangladeshi female group and resulted from family members borrowing money to buy cigarettes, their defiance of religious doctrine and concerns over susceptibility to health risks iv) having negative smoking attitudes resulting from non-smoking parental influence (with either both or one parent being non-smokers). For example:

> "I used to think allow them. They [smokers] need to die, they're a waste of space. [laughs]" (Adan, Bangladeshi male group: pg. 8/ line 214)

> Bharati: I didn't like smoking, I wanted my mum to quit badly and stuff. She was borrowing money off me to buy cigarettes and stuff and that would piss me off.
> I: Hmm, hmm.
> Bharati: And that's why I didn't want her to smoke and stuff.
> I: So you didn't want her to smoke?
> Bharati: I dunno, I just thought it was bad, like cos she wears the Muslim clothes as well so that's even worse.
> (Bangladeshi female group: pg. 57-58/ lines 1314-1320)

> Ayan: The anti-smoking was definitely because of my parents, none of my parents smoked and they always taught me that smoking is bad for you.
> Nadifa: No mine came from like the household innit because my dad used to smoke, and umm cos when we were younger the smoke used to be around us. My mum used to complain about the smoke , used to always hear her complaining, saying it's bad for you, you should stop, stuff like that, that's why I never used to like smoking.
> (Somali female group: pg. 18/ lines 340-345)

These negative attitudes towards smoking often translated into lack of intentions to smoke:

> "Like all the way through primary school I would say that I'm never gonna smoke, I'm never gonna do alcohol and like then it just went kind of set off from there." (David, White British male group: pg. 5/ lines 129-132)

> "I thought it was disgusting and thought 'oh I'm never going to smoke'. I just thought of you know cancer and that it was nasty. I thought for an Asian girl as well it just makes you look cheap really." (Sanchita, Bangladeshi female group: pg. 58/ lines 1330-1332)

Overall this rejection of the smoking world in childhood also indicated how smoking was seen as a deviant behaviour from the norm by participants in all of the groups. Although there was an awareness of the smoking world there was not an inclination to be a part of it.

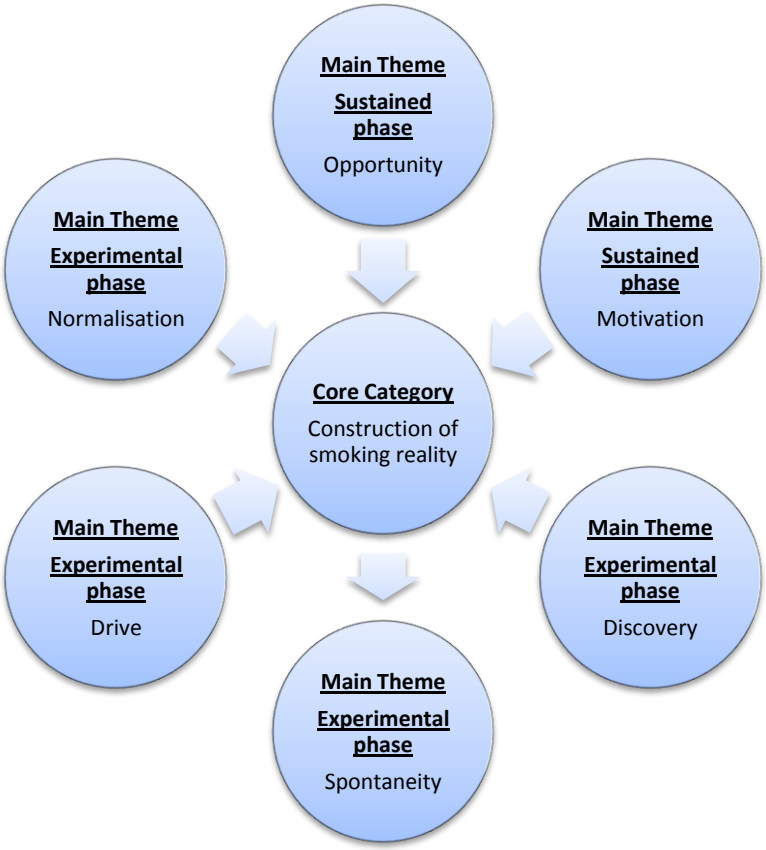
3.2.2. Summary of the pre-initiation stage

Overall the main theme of 'normalisation' constituted the core category of 'construction of smoking fantasy' in the pre-initiation stage. Through establishing the normalisation of smoking, participants at this stage of the smoking process had formulated a normal or deviant perception of the smoking world. The smoking world during the pre-initiation stage was still a fantasy world because the participants had not yet entered it.

3.3. Initiation: Construction of smoking reality

The core category for the initiation stage is ‘construction of smoking reality’, which comprises of the main themes of ‘normalisation’, ‘drive’, ‘spontaneity’, ‘discovery’, ‘motivation’ and ‘opportunity’, as indicated in the figure below:

Figure 3.3. **Core Category and Main Themes for the Initiation Stage**



The initiation stage had two distinct phases. The first phase consisted of the experimentation phase of initiation and the second phase the sustained smoking phase. Each of the main themes will now be discussed in reference to the applicable phase. A summary of how the main themes relate with each other and with the core category will be provided at the end.

3.3.1. Experimentation phase

The main themes applicable for the experimentation phase of the initiation stage were 'normalisation', 'drive', 'spontaneity' and 'discovery'.

3.3.1.1. Normalisation

All of the focus groups indicated normalisation of smoking in the experimentation phase of the initiation stage, with smoking being represented as the norm or as deviant from the norm.

3.3.1.1.1. Smoking as the norm

Smoking as the norm was expressed by the all of the groups and was highlighted through exposure to others' smoking and having a negative image of non-smoking during experimentation.

All of the groups spoke about exposure to others' smoking at the time of experimentation. This included exposure to peer smoking and familial smoking. Exposure to peer smoking involved the majority or some of the peer group smoking and having distinct smoking and non-smoking peer groups at the time of experimentation:

> "When I started smoking there was a big group of us and the majority of the group were already smoking, and it was like only 2 or 3 of us who were just about to have our first one. Like when I started smoking most of the group already did."
> (Robert, White British male group: pg. 23/ lines 673-675)

> "Umm I had like split friends, like a group that smokes and a group that doesn't."
> (Dipika, Bangladeshi female group: pg. 18/ line 420)

Exposure to familial smoking involved having family members of similar age or slightly elder, smoking and having peer-like relationships with them, at the time of experimentation. For example:

> "My uncle smoked normal cigarettes. He smoked quite a lot, he was a heavy smoker...Yea and I used to spend a lot of time with my uncle. I used to be really close to him. He used to be like my best friend." (Anjali, Bangladeshi female group: pg. 9/ lines 212-215)

Next, having a negative image of non-smoking at the time of experimentation was expressed by the Somali male and Bangladeshi female groups and consisted of having a negative image of non-smoking peers, which could even lead to only associating with smokers:

> "In the schools you got like the smokers and then you got like the people playing football there at lunchtime but the people smoking are the cool ones not the ones playing football." (Dalmar, Somali male group: pg. 7/ lines 194-196)

> Sanchita: When I was younger I was only with smokers, that's the funny part.
>
> I: Ok how did you view non-smokers?
>
> Sanchita: They weren't cool...They weren't fun.
>
> (Bangladeshi female group: pg. 89/ lines 2010-2014)

Overall as a result of exposure to others' smoking and having a negative image of non-smoking, smoking being established as the norm was being demonstrated by participants during the experimentation phase.

3.3.1.1.2. Smoking as deviant from the norm

Smoking being deviant from norm at the time of experimentation was expressed by both of the Bangladeshi groups and the White British male group, and consisted of exposure to non-smoking peers. This was indicated by participants who claimed to be the first in their peer group to smoke and also by claims that the peer group started smoking simultaneously:

"All my friends are smokers but they started smoking after I did. I was the first one."

(Bharati, Bangladeshi female group: pg.18/ line 425)

Jack: Basically all the people in the group started smoking at the same time roughly.

Liam: Yea same here.

(White British male group: pg. 23/ lines 677-678)

Hence by entering into experimentation, some participants from the both of the Bangladeshi groups and the White British male group would be the first to defy the non-smoking norm of the peer group.

3.3.1.2. Drive

All of the groups discussed drive for experimentation, which included internal drive and external drive to smoke.

3.3.1.2.1. Internal drive

Internal drive for experimentation consisted of psychological drive to smoke which was expressed by all of the groups. This firstly included to enhance social identity which involved to attain a specific image (e.g. to be cool, adult-like and gangster-like) or to bond with peer group:

Tina: Yea some people say did you smoke because you think it's cool and I think that was part of the reason for me.

Claire: Yea same.

Lisa: Yea that was part of it...

(White British female group: pg. 17/ lines 400-403)

"I just thought like cos in a way yea you feel kinda left out. Even though they're not leaving you out it's just like they're all doing the same thing and then you just feel like 'why can't I do it as well'. You wanna fit in with them." (Deeqa, Somali female group: pg. 15/ lines 295-297)

Psychological drive also included state characteristics. These included i) states of curiosity and wonderment, which arose from observing peer and familial smoking ii) a state of insecurity which fuelled the need to enhance social identity iii) a state of recklessness and iv) a state of rebellion. Examples of wonderment and rebellion include:

Adan: For me I thought 'oh wow look at this guy doing it, it looks kinda mad, there's something coming out of his mouth' so I thought I'll try it as well.

Hasan: And there was this other guy I remember he was making hoops with the smoke. He goes 'I'm going to try this' [imitates with mouth] and then he started smoking like that.

(Bangladeshi male group: pg. 23/ lines 579-583)

"...but I don't think nobody ever smokes for the right reasons but I was just doing it for the coolness and just to fit in I guess...I think with me because I was really

insecure when I was in high school…" (Sanchita, Bangladeshi female group: pg. 7/ lines 181-186)

"When I was younger I used to think I'll do whatever I want I'm not going to give a shit about what anyone else says." (Anjali, Bangladeshi female group: pg. 64/ lines 1457-1458)

Trait characteristics were described by the both of the Somali and Bangladeshi groups and included weakness (e.g. being easily influenced by peers and having a lack of willpower to resist temptation to smoke), stupidity and naiveté of youth. For example:

"...you meet people who influence you like I'm an easily influenced person, I'm not gonna lie. If I see people do it, I'll do it." (Ghedi, Somali male group: pg. 5/ lines 145-146)

"No I don't, I think it's just if you're really weak or if you're...stupid then you start smoking, personally that's what I think." (Ayan, Somali female group: pg. 68/ lines 1346-1348)

Next, the White British male group, Bangladeshi female group and Somali male group discussed experimenting with smoking as a coping mechanism for stress, including family conflict, school stress and general social pressures.

"...but the first time I had a cigarette right I was just really stressed out and really pissed off." (Liam, White British male group: pg. 3/ line 76-77)

> "And I remember when I was at the end of year 9, I had like loooads of like problems cos I got like, you know when you get clocked by your parents and your parents are so hard on you, and then I used to hate them and then I just, I never turned to cigarettes I turned to other stuff like alcohol...And then umm and then I'm in my school and everything and I thought let me stop all that, let me stop drinking yea...And I thought, wait if I can't drink then I'll just move on to smoking." (Mala, Bangladeshi female group: pg. 13-14/ lines 305-319)

The White British male and Bangladeshi female group spoke of individual desire to smoke as a drive for own and others' experimentation. This was illustrated through wanting to smoke and making the choice to smoke regardless of external pressure:

> Sean: I smoked because I wanted to smoke it right, if I wanted to say no, I would have said no but I done it.
>
> David: I asked for one from my mate, I wanted to try it.
>
> (White British male group: pg. 4/ lines 99-101)

Experimentation also resulted from sensation-seeking including smoking as an act of daring, enjoyment and fun which was described by both of the Somali groups and the Bangladeshi female group. Experimenting for fun and enjoyment sometimes resulted from observing others' smoking:

> "...and then I dared myself to smoke it innit." (Erasto, Somali male group: pg. 8/ line 220)

"Yea cos I like used to see the smoke, before he (father) inhaled it and it comes out and the way he handled it, I used to think it looked nice, I wanted to do it too."

(Nadifa, Somali female group: pg. 9/ lines 174-175)

Next, beliefs on smoking as a drive for experimentation were discussed by both of the Bangladeshi groups, the Somali female group and White British male group. These included health beliefs and religious beliefs regarding smoking. Health beliefs comprised of beliefs in being exposed to passive smoking anyway and perceived insusceptibility to smoking health risks (which resulted from exposure to peer smoking), along with perceived insusceptibility to addiction.

Adan: No. There's a group of us, about 10, 11 of us and most of us, I'll say 99 per cent of us smoke.

Hasan: Yea but the ones who don't smoke they're taking it in passively anyway.

Adan: Yea they're taking it in passively anyway.

Hasan: So they say they might as well smoke and probably will soon.

(Bangladeshi male group: pg. 24/ lines 606-610)

Xaali: Yea basically everyday people are smoking around you.

Ayan: Yea you start becoming used to it, your views change, like they're not dying.

Nadifa: Yea you think cos they're not dying I'm not gonna die.

(Somali female group: pg. 14/ lines 273-275)

"My cousin was like 'no don't do it, it's not good for you like, you'll get addicted to it'. Cos they knew but then I never knew, so I was like 'nah trust me I'm not gonna

> get addicted to it' and they were like ok I can smoke now and then later I could stop." (Deeqa, Somali female group: pg. 4/ lines 67-69)

Religious beliefs regarding smoking were mentioned by Mala from the Bangladeshi female group, whereby she mentioned how she used manipulation of religious doctrine as a justification for smoking:

> "So in my mind I thought about like the religious side and I thought it was alright to smoke, yea. I know it's not now but then I fooled myself into thinking it was." (Mala, Bangladeshi female group: pg. 14/ lines 320-321)

Both of the Somali groups expressed experiencing a change from lack of intentions to smoke to intentions to smoke. These changes in intentions stemmed from health beliefs regarding insusceptibility to smoking health risks, being exposed to passive smoking, getting older, being influenced by other smokers, becoming desensitised to originally aversive properties of smoking, assuming a shift in smoker identity and to enhance social identity. All of these were the result of exposure to peer and sibling smoking. Examples of getting older and being influenced by other smokers include:

> Abdi: I couldn't think I was gonna smoke and do the stuff that I'm doing now. I grew up really innit like. It's life.
>
> Taban: Yea it's the same man I used to say I'll never touch it in my life, I'll never go near a cigarette, ever when I was younger but as you get older man I think you just change innit.
>
> (Somali male group: pg. 4/ lines 118-122)

> Ayan: I think the more you are around it, your views change and you start thinking.

Nadifa: And the more used to it you get.

Ayan: Yea you just become so used to it, all your friends smoke.

(Somali female group: pg. 14/ lines 261-263)

Finally, psychological drive for experimentation included behavioural drives, which were discussed by all of the groups in relation to own and others' initiation. These included modelling the smoking behaviour of others including family members, strangers in the street and smoking role models, and the Bangladeshi male group remarked on how this modelling sometimes occurs due to perceived physical reward:

Tina: Yea because when I used to see people smoking on the roads.

Melanie: Yea and the way they like flick their cigarettes butts and you stand there and watch them and wanna do it too.

(White British female group: pg. 5/ lines 96-98)

Ismail: Yea I know this guy, his name is *. And he's 16 and he smokes...He was watching his older Imam [religious leader] smoking and stuff.

Hasan: The Imam's got money and cars innit and so he thinks that if he smokes then he'll get those as well.

(Bangladeshi male group: pg. 21-22/ lines 538-545)

It also included engagement in other substance use, with the Somali male group discussing how a peer's use of cannabis combined with tobacco served as a gateway for smoking cigarettes.

Taban: Yeah but after a while the nicotine in that Zoo [joint] will catch onto you and it will get you onto smoking cigarettes.

> Erasto: I got a friend who rolled a zoo yeah and put a chip [tobacco] in there – he said I'm not smoking – I'm not smoking, I'm not going to smoke no fags and then two weeks down the line he started smoking fags too.
>
> (Somali male group pg.19/ lines 489-493)

3.3.1.2.2. External drive

All of the groups discussed external drives for experimentation in relation to their own and others' experimentation. These consisted of peer group influences and parental influences. Peer group influences were mentioned by all of the groups except the White British female group and included being offered cigarettes by peers and verbal insistence to smoke by peers. The White British male and both of the Bangladeshi groups interpreted verbal insistence to smoke as peer pressure and the Somali female group remarked how it was 'bad peers' that encouraged smoking in others:

> "I was just doing it because I got offered one." (Jack, White British male group: pg. 22/ line 652)

> Hasan: And peer pressure.
>
> Zahir: It's peer pressure. They'll be like take it, take it!
>
> (Bangladeshi male group: pg. 10/ lines 257-258)

> "Yea cos no good friend is gonna tell you to start smoking. It's cos you're around bad people that you start." (Ayan, Somali female group: pg. 41/ lines 794-795)

Parental influences as a drive for experimentation were discussed by all of the female groups in relation to their own and others' experimentation. They comprised of lack of

parental deterrent to smoke, exposure to parental smoking and bad parenting skills. The Somali female group went on to stress that bad parenting was unintentional and that parental influence had the biggest influence on young people smoking.

> "Yea cos I thought like even if I get caught smoking I won't get in trouble so like it doesn't matter and stuff." (Bharati, Bangladeshi female group: pg. 25/ lines 582-583)

> "The parent's influence has carried on cos by having smoked in front of us." (Claire, White British female group: pg. 5/ line 95)

> "Parents yea when they say to their boys 'you're gonna end up doing this or that, end up in prison and stuff' then that's like what makes the boy end up like going down that road. Cos unless, you know parents say to their son 'oh I hope you do well, go to college you're gonna be good, you're gonna be a big-time lawyer,' they'll end up getting into bad habits like smoking." (Nadifa, Somali female group: pg. 26/ lines 503-507)

> Xaali: They [parents] don't mean to do it.
>
> Nadifa: Yea but it just comes out.
>
> Xaali: It just comes out.
>
> Nadifa: Especially when they're angry.
>
> Ayan: They have the most influence; I think they have the most.
>
> Nadifa: Yea parents have the most influence on their children smoking.
>
> Xaali: More than friends.
>
> (Somali female group: pg. 27/ lines 520-537)

Overall it can be seen how drive for experimentation was the result of both internal and external factors, which highlights the importance of both individual and social factors in experimentation. This stage represents the development of the transition of the participant's fantasy smoking world becoming a reality smoking world.

3.3.1.3 Spontaneity

All of the groups indicated the spontaneity of their experimentation, which included it being spontaneous or pre-meditated, along with the preparation involved for experimentation. Spontaneous experimentation was expressed by the Bangladeshi female, White British male and Somali male groups, which was indicated through opportunistic access to cigarettes and impulse to smoke. Opportunistic access involved others (e.g. peers and acquaintances) offering cigarettes and accidently finding family members' cigarettes.

> "Umm I was at my friend's video shoot and one of the girls there was smoking and she asked if I wanted to try it so I tried it..." (Dipika, Bangladeshi female group: pg. 17/ lines 399-400)

> "First time I started I was young. I found a cigarette in my house somewhere innit. I think it was my dad's innit and I was thinking why not." (Erasto, Somali male group: pg. 8/ lines 218-219)

Impulse to smoke was demonstrated by Sanchita from the Bangladeshi female group who stated her moment of discovery did not go as originally planned due to her impulsive drive to have a cigarette:

"I wanted to first smoke by myself but it didn't happen that way because once I like wanted it so badly and my friend was with me so I had it." (Sanchita, Bangladeshi female group: pg. 6/ lines 151-153)

Next, pre-mediated discovery was discussed by all of the groups and was indicated through prior accessing of cigarettes before experimentation. This was done through purchasing cigarettes and requesting cigarettes from peers.

"I bought a whole packet of cigarettes to smoke for when it was my first time." (Melanie, White British female group: pg. 4/ line 65)

"...I just thought oh I want to try it so I so asked them [peers] for one..." (Deeqa, Somali female group: pg. 4/ line 66)

Finally, preparation for experimentation involved taking cautionary measures with location to avoid discovery by teachers and parents, which was mentioned by the Bangladeshi female group:

"Around the back because there used to be cameras in my school. It was really bad. We smoked underneath the cameras so no one would see us [laughs]." (Sanchita, Bangladeshi female group: pg. 23/ lines 535-536)

Overall it can be seen how the process of experimentation and entering into the smoking world was a more instantaneous event for some participants and a more considered process for others.

3.3.1.4. Discovery

All of the groups expressed undergoing a process of discovery during experimentation. This involved a process of psychological and physiological discovery.

3.3.1.4.1. Psychological discovery

Psychological discovery firstly comprised of behavioural discovery. Behavioural discovery involved discovery of the smoking act, which was discussed by all of the groups aside from the White British male group. This firstly involved having initial lack of awareness on how to engage in the act and also involved gaining gradual awareness on how to engage in the smoking act. For some participants, gaining gradual awareness arose from observing peers' technique and peers assisting with technique:

> "Yea and you don't know what to do...so you just take it and then you think am I supposed to inhale it or not?" (Melanie, White British female group: pg. 2/ lines 13-17)

> Hasan: You thought you might as well smoke the rest as you get used to it.
> Adan: and then you start getting used to it, yeah.
> (Bangladeshi male group: pg. 4/ lines 106-107)

> Melanie: And then probably as you inhale it more and you see all your other friends doing it.
> Claire: So you pick up how to do it.
> (White British female group: pg. 2/ lines 19-20)

> "But one of my white mate's called * taught me how to inhale it and then after I found it easier and easier." (Abdi, Somali male group: pg. 2/ lines 54-55)

Psychological discovery of the smoking world also involved experiencing positive or negative psychological responses during experimentation, which was discussed by all of the groups except the White British female group. Firstly, positive psychological responses included having a positive image, state, attitudes and emotions when smoking and also experiencing fulfilment of drive for initiation during experimentation. With regards to positive image and state this was mentioned by the Bangladeshi female group who spoke about feeling cool, like 'a bad girl', confident and powerful when engaging in the smoking act.

> "I used to think I'm a bad girl [laughs]....You know thinking I was so cool [laughs]." (Mala, Bangladeshi female group: pg. 14/ lines 323-325)

However, Sanchita commented on how this effect was short-lived and only confined to the moment of engaging in the act:

> "...and then after I did it, I just didn't feel cool anymore....but when I didn't have a cigarette in my hand I didn't feel cool anymore." (Sanchita, Bangladeshi female group: pg. 6/ lines 153-160)

Positive attitudes and emotions during experimentation were expressed by the Bangladeshi female and both of the Somali groups. These were directed towards the physiological discovery process of smoking, such as liking and enjoying the physical symptoms and sensations induced by smoking:

> "...for me it was like, it felt kinda like good the way it goes in and comes out and it felt good to me. The taste didn't really bother me. I thought it tasted nice." (Anjali, Bangladeshi female group: pg. 10/ line 230-23

"I enjoyed my fag to be honest." (Abdi, Somali male group: pg. 4/ line 102)

Finally, both of the Bangladeshi groups and Somali female group spoke of fulfilment of drive for initiation during experimentation. This involved the act of smoking having the desired outcome, which was to stay awake for a game being played with peers and also to fit in with peers:

"It gave me a head rush but I was still awake for the game which was the point!" (Zahir, Bangladeshi male group: pg. 23/ line 574)

"Yea, it was alright then, I straight away felt less left out [of peer group]." (Deeqa, Somali female group: pg. 16/ line 299)

Negative psychological response included experiencing negative emotions, attitudes and feelings during discovery of smoking world, which was expressed by all of the groups except the White British female and Bangladeshi male groups. Negative emotions involved experiencing emotions of fear and embarrassment during discovery, which were described by the White British male, Somali female and Bangladeshi female groups. Fear resulted from inexperience of the smoking act and risk of parental awareness when engaging in the act, and embarrassment resulted due to lack of mastery over smoking technique in front of peers.

"Yea, I found it scary more, cos you don't know how to do anything, it's just instincts." (Xaali, Somali female group: pg. 6/ line 124)

"I felt scared umm if my parents were gonna find out or not." (Robert, White British male group: pg. 3/ line 71)

> "...and we started smoking and I couldn't do it properly [laughs] and they [peers] looked at me and they're like 'you're mad', they started taking the piss. They were like you can't smoke properly I was like seriously I got so embarrassed." (Mala, Bangladeshi female group: pg. 14/ lines 329-332)

Negative attitudes were expressed by all of the groups except the White British female and Bangladeshi male group, which were directed to the physiological discovery of smoking. This involved disliking the physical symptoms and sensations experienced when smoking. Participants from the Somali male and female groups remarked on how this resulted in intentions not to smoke again:

> "...I used to cough. So I didn't used to like it..." (Roble, Somali male group: pg. 2/ lines 61-62)

> "You start choking; feels disgusting, you think I'm never gonna do it again." (Nadifa, Somali female group: pg. 7/ line 142)

Finally, the Bangladeshi female and Somali male group described experiencing negative feelings during experimentation, which comprised of feeling sinful due to expected familial disapproval and hypocritical due to previous intentions not to smoke:

> "With me in the beginning when smoking I felt really bad. I felt like I was carrying out like a huge sin." (Sanchita, Bangladeshi female group: pg. 34/ lines 798-799)

> "Obviously at the beginning you say to your friends 'oh no I won't smoke, I won't smoke'... So you do feel hypocritical when you start." (Somali male group: pg. 20-21/ lines 516-519)

3.3.1.4.2. Physiological discovery

Physiological discovery of the smoking world referred to the physical symptoms and physical sensations experienced when engaging in the act of smoking, which were discussed by all of the groups. Physical symptoms included coughing, choking, head rush, dizziness, light headedness, headache, nausea and feelings of relaxation. These effects were experienced due to unawareness of smoking technique and also the effects of the cigarette contents:

> "Yea and you don't know what to do so you choke. You just kinda go like [coughs] and choke for like a good ten minutes." (Melanie, White British female group: pg. 2/ lines 13-14)

> Hasan: Yeah I just felt sick and that.
>
> Adan: Yea.
>
> I: You felt sick?
>
> Hasan: Well I vomited and that.
>
> (Bangladeshi male group: pg. 3-4/ lines 98-101)

With regards to physical sensations experienced, Anjali from the Bangladesh female group described the physical sensation of smoke coursing through her body:

> "Umm it's like this weird feeling of something going through your lungs..." (Anjali, Bangladeshi female group: pg. 10/ line 229)

Overall it can be seen how the process of experimentation was a path of discovery for the participants involving both a psychological and physical process of discovery. This

constituted as the first foray into the smoking world and the beginning of development of smoking reality for the participants.

3.3.2. Sustained smoking phase

The main themes identified for the sustained smoking phase of the initiation stage were motivation and opportunity.

3.3.2.1. Motivation

All of the groups described their motivation for sustained smoking following experimentation. For some participants this motivation was present immediately or a short time after experimentation but for some participants in the Bangladeshi female group this occurred up to two years after the period of experimentation. Motivating influences occurring after a shorter-term basis will be discussed first followed by those occurring a longer time after experimentation.

3.3.2.1.1. Short term

Motivating influences for sustained smoking that occurred a short time after experimentation were discussed by all of the groups. Firstly, these included maximising usage of purchased cigarettes, which was mentioned by the Bangladeshi male group:

> "The thing is yeah I bought a deck for when I started. You thought I've had one, I might as well smoke the pack, then you smoke it innit." (Hasan, Bangladeshi male group: pg. 4/ lines 103-104)

Next, they involved gaining emotional pleasure from smoking which was expressed by all of the groups. This included finding the experience and physiological effects of smoking fun, enjoyable and pleasurable:

> "I just carried on smoking, like it just felt bare [very] nice, like do you get me?" (Claire, White British female group: pg. 4/ line 69)

> "...but then you think ah it's still cool I still wanna do it, when you take that one pull that's when you think yea I need to carry on with this, nice feeling." (Hawiiya, Somali female group: pg. 44/ lines 855-856)

They also included assisting with peer group bonding. Sean from the White British male group described how he sustained smoking as all his peers were doing it:

> "I just wanted to carry on for some reason, I don't know particularly because everybody else is doing it..." (Sean, White British male group: pg. 4/ lines 119-120

Another motivating influence was to practise smoking technique to master the technique which was mentioned by the Somali female and Bangladeshi female groups. This was often done to enhance social identity within the peer group which in some cases had been jeopardised due to experiencing difficulties with the smoking technique.

> "...and then I started doing it by myself, and then I dunno I started doing it by myself just to practice so that it wasn't embarrassing like, cos obviously I didn't know how to smoke, every time I would cough, er inhale it, every time I would inhale it I would start coughing so at that time I thought yea I need to learn how to do it like my friends because it looked cool, everyone was smoking..." (Ayan, Somali female group: pg. 3/ lines 48-52)

> "...and I remember I used to sit in my, in my window cos my window is quite open space and I used to sit there and I used practice smoking [laughs]...I had to smoke so I could too I could like cough, not cough anymore...Cos people took the piss and said I couldn't do it properly and now I just wanted to prove that I just could do it [laughs]." (Mala, Bangladeshi female group: pg. 14-15/ lines 334-338; 352-353)

Next, participants from the White British male and Bangladeshi female group spoke of how they sustained smoking as it served as a coping mechanism to deal with stress. Anjali from the Bangladeshi female group also spoke about how smoking was an easier to conceal coping mechanism for stress, than her previous coping strategy of self-harming.

> "I said stress, like when I was stressed out I would just like have a fag and like I would like feel different, feel alright." (Liam, White British male group: pg. 4/ lines 113-114)

> "For me smoking was like self-harming. I used to self-harm anyway but it was just another way... And I just thought 'oh whatever I don't really care'....My mum yeah, if you're self-harming people realise you've got scars and like my mum used to realise, like she used to see me lying in bed and she used to thinks 'where's that from'? But with smokers you can't really say nothing cos she knows that I smoke anyway so it was just another way like to get her off my case really...Basically, I stopped self-harming and I started smoking a lot more. So it was like a substitute." (Anjali, Bangladeshi female group: pg. 52/ lines 1190-1202)

Participants from the Bangladeshi female group also spoke about how their sustained smoking behaviour served as an act of rebellion against their parents:

Bharati: Yea, for me it was. Yea kind of, cos I felt like, I don't know what's the word? Defiance or something like that.

I: Ok

Bharati: Yea that word, I was doing it to get on their nerves on purpose, yea I kind of wanted to get caught like cos I was smoking in school as well, in the school building so it was kinda like I wanted to get caught and stuff.

I: Why do you think that was?

Bharati: I dunno man, going through some tough times at home and just, I dunno. I just wanted to annoy my parents.

(Bangladeshi female group: pg. 95/ lines 2141-2149)

The White British male group discussed how addictive personality traits could be responsible for others' sustained smoking:

I: So do you think trying that one continues to make you need them?

Jack: Not really.

David: But if you've got an addictive personality then yea.

(White British male group: pg. 21/ lines 617-619)

Finally, the Bangladeshi female, Somali female and White British male group mentioned how they also sustained their smoking due to smoking health beliefs. These consisted of perceived unawareness and insusceptibility to getting addicted to smoking:

"Cos I was quite young then I wasn't scared I'd get addicted to it because I didn't know anything about that. I was like 10. I was just in primary school." (Anjali, Bangladeshi female group: pg. 11/ lines 251-253)

3.3.2.1.2. Long-term

Motivating influences occurring a longer time after experimentation were discussed by participants from the Bangladeshi female group and consisted of smoking as a coping mechanism for stress and social anxiety, and for peer group bonding:

"...and then in year 9 I was really going through a lot of shit with the family, people were passing away and stuff like that, and it was really hard, and then that's how I started properly really, that's the main reason." (Priya, Bangladeshi female group: pg. 4/ lines 115-117)

"I just think it was a confidence thing as well isn't it? Like when holding a cigarette you feel like, I dunno, you feel like...It's something supporting me I guess." (Sanchita, Bangladeshi female group; pg. 49/ lines 1138-1141)

"And umm, basically I think towards the end of year 11 that's when I started smoking regularly cos like my close friends were smoking." (Dipika, Bangladeshi female group; pg. 17/ lines 413-414)

Overall it can be seen how varied motivation to sustain smoking and to remain in the smoking world was for participants.

3.3.1.5. Opportunity

Exploring the Process of Smoking

Opportunity for smoking was discussed by all the groups and involved being granted opportunity, denied opportunity and creating opportunity to smoke.

Firstly, being granted opportunity involved being able to access cigarettes, despite being underage to purchase them, which was mentioned by all of the groups. Sources of access included stealing cigarettes from family members, asking others (peers, family members, strangers on the street) to purchase cigarettes, sharing peers' cigarettes and being served in shops.

> "I got someone else to buy it for me...Anyone like from the streets. I'll ask him 'excuse me mate can you buy me some cigarettes please'?" (Salman, Bangladeshi male group: pg. 6/ lines 161-164)

It also involved being able to smoke in forbidden locations, which was mentioned by all of the groups apart from the Somali female and White British male group. Participants spoke about being able to smoke at school due to lack of anti-smoking measures and lack of enforcement of non-smoking policy:

> Abdi: At first yeah when we was in secondary school nothing used to be strict. We used to smoke in the playgrounds...
>
> Taban: Yea.
>
> Abdi: Everyone was really naughty. Everyone just used to go around the back and just smoke teachers wouldn't say nothing.
>
> Taban: Basically the school, it was a bad school.
>
> Abdi: We never had no fear at school. That's what led us on a bit more, not like 'watch out for the teachers,' none of that.
>
> (Somali male group: pg. 7/ lines 181-188)

Next, being denied opportunity to smoke was discussed by the White British male group and involved being denied access to cigarettes by strangers refusing to purchase them:

> "Some of them used to do it but some of them yea would just stop and give you some bare lecture like 'you should stop smoking, you should stop smoking,' and it was like I only asked you to get me them." (David, White British male group: pg.12/ lines 355-357)

Finally, creating opportunity to smoke was discussed by the White British female group and both of the Bangladeshi groups, which involved overcoming barriers to accessing cigarettes and locations to smoke. Firstly, with regards to barriers to location to smoke, these comprised of parental and teacher discovery of smoking and enforcement of non-smoking measures at school. Opportunity to smoke was created by taking cautionary measures when smoking in public and at school, such as being on guard and smoking in concealed locations and by discovering new locations to smoke at school:

> "I remember when I was younger and I used to go shopping at the local mall. I'll be walking down the street and I'd really want a cigarette and I'll say to my friend 'come on let's just go around the back roads' and she'd say 'oh do we have to, can't we just smoke here' and I'm like 'no I have to go down the end as I don't want to be seen'." (Sanchita, Bangladeshi female group: pg. 40/ lines 922-925)

> Melanie: They blocked off every smoking corner in our school.
>
> Claire: And people still find a place to smoke.
>
> (White British female group: pg. 6/ lines 124-125)

Barriers to accessing cigarettes also involved parental discovery and refusal of strangers to purchase cigarettes. Opportunity to smoke was created by taking cautionary measures when stealing cigarettes, exercising perseverance when being refused access by strangers on the street and seeking alternative means to access when being unable to store cigarette boxes at home:

> "Obviously when I was like 13 or 14 yeah I used to know where she [grandmother] used to keep her rizzla paper and the tobacco cos she's old she doesn't know how much she's got so I just used to take packets from her. And she used to buy it in advance and just leave it there so I used to just take the packets. I used to do the same thing with cigarette boxes from my uncle – he had a lot of duty free cigarette boxes whenever we used to go to Bangladesh and so I knew he wouldn't miss them."
> (Anjali, Bangladeshi female group: pg. 60-61/ lines 1386-1391)

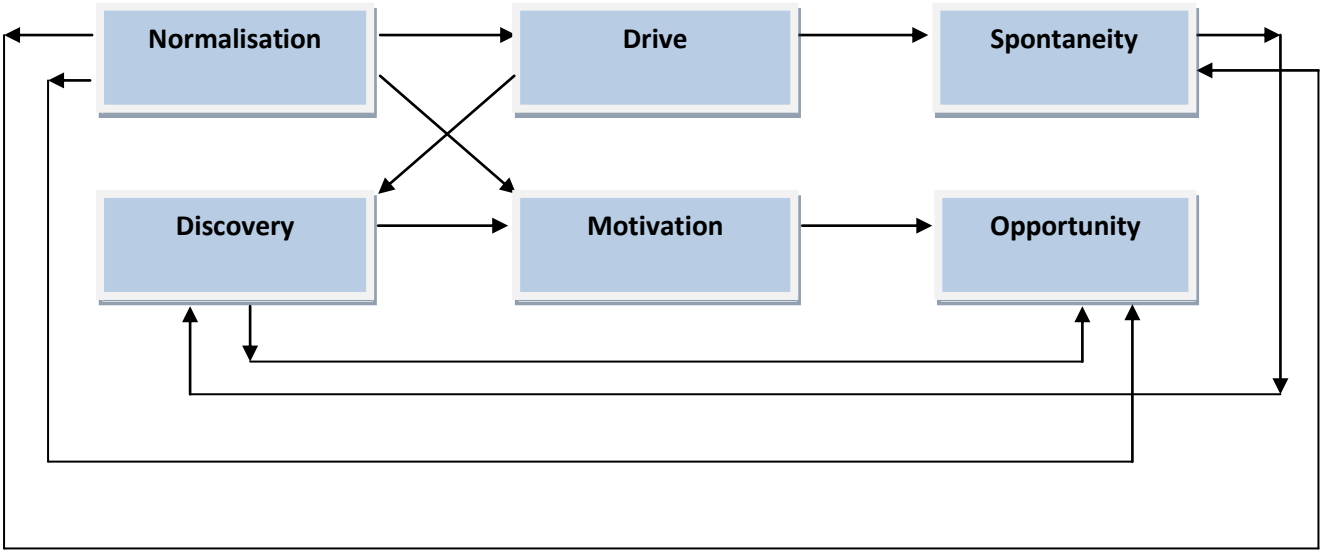
> Robert: You just wait for the next person [in the street].
> David: Yea you just have to wait for the next person.
> (White British male group: pg. 12/ lines 359-360)

Overall having opportunity to smoke influenced the ability of participants to remain in the smoking world. It could be seen how some participants overcame obstacles in order to sustain their smoking behaviour which indicates the powerful force of motivating influences discussed earlier, during this stage of the smoking process.

3.3.3. Summary of the initiation stage

Overall the main themes of normalisation, drive, spontaneity, discovery, motivation and opportunity constituted the core category of 'construction of smoking reality' for the initiation stage. At this stage of the smoking process, participants had now entered the smoking world and as a result of the main themes had begun to construct their own smoking realities. The figure below highlights the links between each of the main themes in the initiation stage:

***Figure 3.4*. Links between the Main Themes for the Initiation Stage**



It can be seen from the figure above that normalisation of smoking which consisted of viewing smoking as the norm or deviant from the norm impacted on participants' drive for experimentation, the spontaneity of their experimentation, their motivation for sustained smoking and also the opportunity for sustained smoking.

Next, the drive for experimentation which was external or internal in nature influenced the spontaneity of experimentation and discovery of the smoking world.

Spontaneity of experimentation which was spontaneous, pre-mediated and prepared had a direct influence on discovery of the smoking world.

Discovery of the smoking world which was behavioural, psychological and physiological in nature impacted on participants' motivation for sustained smoking and also their opportunity for sustained smoking.

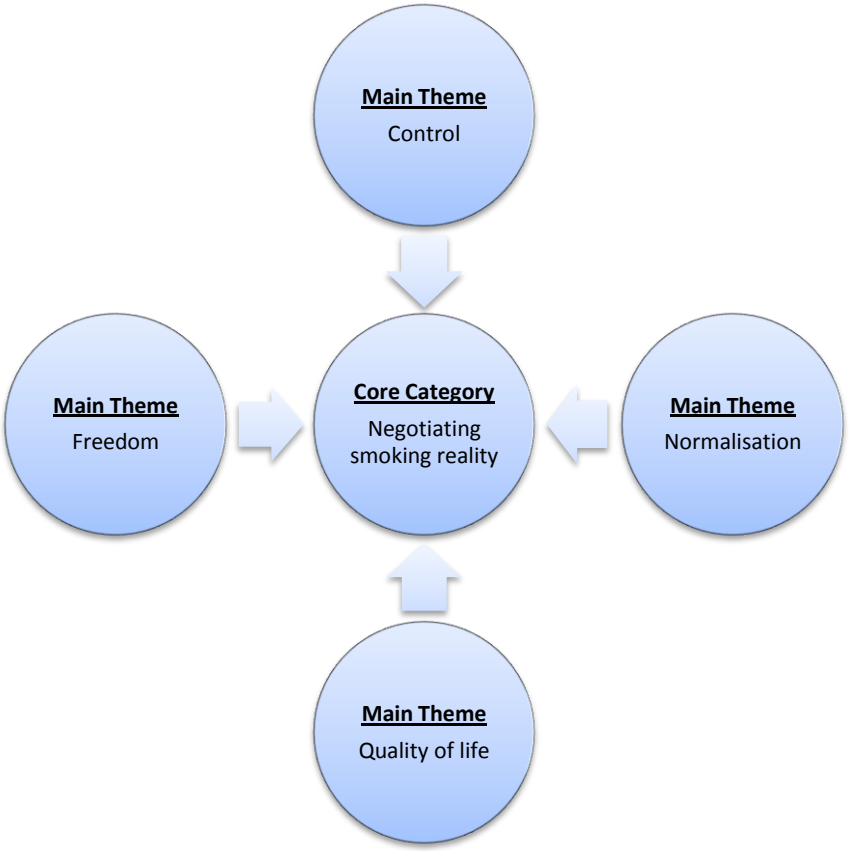
Finally, motivation for sustained smoking had a direct impact on opportunity to smoke.

Overall it can be seen how the theme of normalisation appears to be the starting point from which the majority of other themes generate.

3.4.Maintenance: Negotiating smoking reality

The core category for the maintenance stage is 'negotiating smoking reality' which comprises of the main themes of 'freedom', 'control', 'quality of life' and 'normalisation', as indicated in the figure below:

***Figure 3.5*. Core Category and Main Themes for the Maintenance Stage**



Each of the main themes will now be discussed and then a summary of how the main themes relate with each other and with the core category will be provided at the end.

3.4.1. Freedom

The main theme of freedom referred to freedom of smoking behaviour and consisted of barriers to smoking freedom, facilitators to smoking freedom, reclaiming smoking freedom and relinquishing smoking freedom. These will now be discussed in turn.

3.4.1.1. Barriers to smoking freedom

All of the focus groups described barriers to their smoking freedom. This consisted of legal, socio-cultural, financial and psychological barriers.

3.4.1.1.1 Legal barriers

All of the groups discussed legal barriers to their smoking freedom. These included legal barriers to their access of cigarettes and to the location in which they could smoke. Legal barriers to access were mentioned by all of the groups apart from the Bangladeshi male group, who spoke about the legal tobacco purchase age and graphic images now being displayed on cigarette boxes. Firstly, in regards to the legal tobacco purchase age, the groups described difficulty in buying cigarettes due to the age of tobacco purchase having been raised to 18 years old. For example, The Bangladeshi female group discussed being served one day and not the next.

> Priya: I mean, it's a bit annoying when you have been served by the same shop for ages and then one day they just decide not to serve you and it's like ok what is going on?
>
> Mala: Yea it happened to me last week.
>
> I: Yea?
>
> Priya: It's really annoying. You think okay you've been serving me from God knows how long, what the hell is wrong with you?
>
> I: Ok.
>
> Mala: It happened to me like the day before, no on Eid day actually, this Eid day.
>
> Priya: God that's even worse.
>
> (Bangladeshi female group: pg. 42/ lines 965-973)

Also all of the groups discussed how the law was enforced which included being asked for ID and the Bangladeshi female group also mentioned being lectured at by shopkeepers. The Somali and White British female focus groups described an inconsistency in being able to purchase cigarettes from different shops which was often dependent on being in or out of the

local area. The Somali male group described being denied access in out of local area shops and the White British female group the reverse, for example:

> "When I go into the shop and say can I buy fags they say 'nah sorry you ain't got ID now get outta the shop'... You buy cigarettes and one thing if you don't have any ID on you but they know you, you used to buy cigarettes from the shop like week in week out they will allow you. That's your local but if you have to go into a different area and no ID they'll tell you to get out of the shop." (Roble, Somali male group: pg. 21-22/ lines 537-547)

With regards to graphic images, not all of the participants had viewed them yet due to the recent change in law but some had. For example the White British female group stated:

> Melanie: And now with the cigarette boxes, they have, they have pictures.
>
> Claire: I ain't seen them yet.
>
> Melanie: Ain't you? My brother's got two boxes at home. Yesterday's one they had teeth on them, and they were bare [very] messed up. Today's one he's got this little boy, this little kid, he's only like about 2, blowing out smoke from his mouth.
>
> I: Ok.
>
> Tina: Yea I had one with a baby on it dying, that was disgusting. It was my box but then I gave it to you cos it was horrible [to Lisa].
>
> Lisa: Yea, I remember the teeth one.
>
> (White British female group: pg. 9/ lines 197-205)

Next, all of the groups spoke about legal barriers to the location in which they could smoke. This consisted of the illegality of smoking on public transport and the recent ban on

smoking in enclosed public spaces. For example, the White British male group described receiving negative public reaction when attempting to smoke at a bus stop:

> Liam: Some people kind of give you weird looks. They're like standing at a bus stop right and I'm sitting in rush hour.
>
> Jack: Yea you have to have a cigarette and you get some dodgy looks.
>
> Liam: Yea you get some dodgy looks when someone will come down and sit next to you...
>
> (White British male group: pg. 20/ lines 589-592)

3.4.1.1.2. Socio-cultural barriers

All of the groups discussed socio-cultural barriers to their smoking freedom. These included i) familial barriers ii) community barriers iii) peer barriers and iv) religious barriers.

i) Familial barriers affected participants' access to cigarettes, the location in which they smoked, their general smoking behaviour and disclosure of their smoking behaviour. Firstly, familial barriers to access were mentioned by the Bangladeshi female group and involved parental rejection of smoking behaviour. Mala described how her mum destroyed her cigarette supplies at home:

> "The most worst thing she [mother] done was I have like boxes in my house and the most worst thing is she knew where my spots were, where I would hide them and I come home and I see everything was just snapped in half..." (Mala, Bangladeshi female group: pg. 30/ lines 698-701)

Next, parental barriers to location were discussed by all of the groups except the White British female and Bangladeshi male group and consisted of risk of parental discovery

and parental dictation on smoking location. Risk of parental discovery was a barrier when smoking at home or in public and was discussed by the Somali male and Bangladeshi female group:

> Dalmar: There's times when you walk around and you think 'ah is my mum around'.
>
> I: Ok
>
> Dalmar: I look around.
>
> Ghedi: I do definitely.
>
> (Somali male group: pg. 17/ lines 428-431)

The Bangladeshi female, Somali female and White British male groups described parental dictation on smoking location. This included being forbidden to smoke at home due to parental anti-smoking attitudes, being forbidden to smoke publicly due to parental desire for preservation of community reputation, not being able to smoke in front of younger family members due to concerns over second-hand smoke and not being able to smoke in front of elder family members due to it being considered disrespectful.

> "...He's [dad] never let me smoke in the house..." (Robert, White British male group: pg. 6/ lines 175-176)

> "...cos as a Muslim girl as well I can't be going outside and smoking on the road and like so my mum was just like if you're gonna smoke I'll prefer you to do it inside the house where other people see you and be like 'ohh her daughter's smoking, this is bad'." (Deeqa, Somali female group: pg. 19/ lines 363-366)

> "When I used to go outside and smoke and then come back inside my mum didn't used to not let me hold my little baby brother because I smelled of cigarette smoke. I

had to wait a bit until the smoke went. She didn't like the smell in the house. She used to be like 'don't smoke when you're around your little brother'." (Anjali, Bangladeshi female group: pg. 78/ lines 1760-1764)

"Well my mum when in the house, she tells me don't show it to him [uncle] as it's disrespectful..." (Deeqa, Somali female group: pg. 21/ line 404)

Next, familial barriers to general smoking behaviour were mentioned by all the groups which consisted of familial psychological rejection of the smoking behaviour. This psychological rejection firstly comprised of behavioural rejection which was discussed by all the groups and involved actual or anticipated verbal reprimand, physical reprimand and instructions for cessation by family members. Verbal reprimand included verbal threats (e.g. threats of disownment and locking in the room) and verbal chastisement involving shouting and telling off:

"So he [dad] was like I'm not going to ask you if you smoke but if I catch you you're going to be out of my house. So that's it - no talk. No sitting me down or none of that." (Ghedi, Somali male group: pg.13/ lines 336-337)

Physical reprimand involved being physically disciplined by parents:

Vicky: Yea I thought they were gonna batter me.

Lisa: Innit, she's been caught but like...

Claire: I remember when you got hit by your arse by your dad when she got caught smoking (laughs).

Vicky: I got caught smoking a couple of weeks ago.

Lisa: Aww.

> Claire: Her dad saw her smoking and slapped her, it was so funny (laughs).
>
> (White British female group: pg.19-20/ lines 454-460)

Instruction for cessation by parents included verbal requests for cessation which often stemmed from concern over negative health effects of smoking. Some requests were more demanding and others more empathic and pleading. These also sometimes led to parental intervention to aid cessation, for example through provision of health literature, lecturing and monitoring of participant's cigarette supply. For example:

> "...Then she [mum] started trying to make me stop smoking by buying me cigarettes...and she used to buy me cigarettes and she was like you can only take 2 a day and then hoped to like wean me off..." (Anjali, Bangladeshi female group: pg. 11/ lines 263-267)

Familial psychological rejection also included family members having actual or anticipated negative feelings and attitudes towards smoking along with a negative image of smoking, which was discussed by all of the groups, except the Bangladeshi male group. Negative feelings included experiencing feelings of upset, disappointment, and anger when discovering participants' smoking behaviour, which were mentioned by all the female groups and the White British male group.

> "Errr I think my dad was more disappointed than my mum cos since up til this day like he never wants to see me have a fag..." (Robert, White British male group: p. 6/ lines 175-176)

Negative attitudes towards smoking consisted of a dislike of smoking and judgmental attitude towards smoking, which were mentioned by the White British female, Somali male and Bangladeshi female group.

> Sanchita: It was my 16th birthday and I had to ask her [sister] can I just have a cigarette (laughs) cos I really wanted one. So my sister's very reserved, she's very conservative, she's very prim and proper, you know, this is bad and you're going to hell kind of thing.
>
> I: Ok oh.
>
> Sanchita: Well she won't really say that but I know that's what she's probably thinking. I think she's very judgemental my sister.
>
> (Bangladeshi female group: pg. 37/ lines 862-868)

Negative familial image of smoking was expressed by the Somali female group and involved non-smoking parents equating smoking with the use of hard drugs.

> "...they think it's the worst thing to do ever, like drugs, although I know smoking is a drug but like heroin or something." (Ayan, Somali female group: pg. 54 /lines 1074-1075)

The Somali female and Bangladeshi female groups also discussed psychological familial rejection of their smoking behaviour based on factors relating to tradition, gender, religion and age. For example, the Somali female group spoke of parents having a negative image of female smokers (e.g. classifying them as 'bad' and as 'boys') due to their defiance of traditional smoking gender norms and breaking traditional stereotypes of being a female.

> Xaali:...parents feel that girls are the good ones, so like if I'm smoking yea, they're gonna say 'oh yea you're just like a boy, behaving just like a boy' and they're just gonna make a big deal out of it. That's what they would be like.
>
> Nadifa: I think with girls like especially in my family, there is that thing of you should be good. Now my parents feel like that my brother's like better than me. Cos I'm a girl I'm meant to be good and now they know I smoke they think I'm bad.
>
> (Somali female group: pg. 28/ lines 540-546)

Hawiiya from the Somali female group also raised the impact of her age by discussing her granddad's negative attitude towards youth smoking, which he expressed after discovering her smoking behaviour. Mala from the Bangladeshi female group described how a combination of her age, gender and religion dictated her parents' negative attitude towards her smoking.

> "My granddad goes to me oh, and he's kinda old innit, he goes you're too young to smoke..."
>
> (Hawiiya, Somali female group: pg. 36/ lines 711-712)

> "But obviously cos we're under age now and cos we're Muslim girls our parents wouldn't like it..." (Mala, Bangladeshi female group: pg. 22/ lines 419-422)

Finally, familial barriers also impacted on participants' disclosure of their smoking behaviour due to psychological parental protection, relationship with parent and negative affect resulting from parental retribution. Firstly, psychological parental protection was discussed by both of the Somali groups and involved not wanting to disclose smoking

behaviour to parents due to wanting to protect parents' emotions (e.g. sparing them from upset feelings) and image (i.e. preserving their reputation in the community).

> "You can't tell your parents I'm gonna start smoking now, you know...because they're gonna be upset and you don't wanna upset your parents especially if they raised you well." (Ayan, Somali female group: pg. 23/ lines 452-455)

Relationship with parent was also regarded as a barrier to disclosure, which was mentioned by both of the Somali groups and the Bangladeshi female group. This included not having a 'friend-like' relationship with parents, which the Somali male group thought was a cultural distinction between white communities and other ethnic minority communities.

> Taban: Nah do you know what it is yeah between like the Somali like and other communities except for the white communities it's like some people don't have that kind of bond with their parents where they can like sit and talk to their parents so they're gonna have to hide it from them but like most white people and their mums are like best friends and that. They talk to each other every day. But most, most kids these days yeah they just go come in and go straight to their room.
>
> I: Hmm.
>
> Taban: They duck and dive innit. So if you have that connection with your parents you'd sit down and talk to them about it.
>
> (Somali male group: pg. 12/ lines 302-314)

However, Nadifa from the Somali group commented on how this friendship would form as she got older, which lead to disclosure to her mother.

> "...obviously you can't tell them straightaway but gradually after like a while then you start becoming friends with your parents and that then you can tell them. But not with

your dad innit cos most dads are stricter." (Nadifa, Somali female group: pg. 22/ lines 420-422)

Also negative affect from parental retribution was expressed by the Somali groups and consisted of feeling fear and shame over parental disclosure due to possible retribution.

"...most of the time like I was scared to tell her [mother] that 'ah I've started smoking'." (Deeqa, Somali female group: pg. 24/ lines 457-458)

ii) Community barriers impacted on participants' access to cigarettes, the location in which they smoked and their general smoking behaviour. Firstly, with regards to access to cigarettes, community barriers consisted of negative community smoking attitudes when asking strangers on the street for cigarettes. These were expressed by the Somali female group. They involved age based negative community smoking attitudes, which involved encountering negative community attitudes towards youth smoking and they also included religious-based negative community smoking attitudes, which involved being perceived as a disgrace to the Muslim religion by the Muslim community.

Ayan: Or some people, I, sometimes I used to ask people on the roads.

I: Yea?

Ayan: Even now, just for a cigarette.

Nadifa: I do too.

Xaali: But sometimes they don't give them, saying how old are you?

Ayan: Yea.

Amina: Yea.

Nadifa: They say aren't you young...

(Somali female group: pg. 35-36/ lines 694-701)

Amina: Sometimes I ask in my headscarf...

Ayan: Cos a lot of us started smoking before.

Amina: You think the Muslim people will say 'look at her she's smoking, giving us a bad name...'

Ayan: Well they don't really say anything but you know when their head turns.

Nadifa: Yea and the way they look at you.

Xaali: Yea everything.

(Somali female group: pg. 36-37/ lines 714-728)

Next, with regards to location of smoking, community barriers involved negative community smoking attitudes, risk of parental disclosure via community and risk of community discovery. Negative community smoking attitudes impacted on being able to smoke in public locations and were discussed by the Somali and Bangladeshi female groups. Similar to when accessing cigarettes some of negative community smoking attitudes were based on religion and gender, which were expressed by the Somali female group and again involved being viewed as a disgrace to Muslims for being a Muslim female smoker.

"The issue is like most like Muslim girls don't smoke, so like if another Muslim person sees you smoking they'll think like you're, umm. I'm wearing the Muslim clothes now and so if I'm smoking outside the college and like someone religious sees me they'll be like that's a disgrace to Muslims so it's not really a good image like to show." (Deeqa, Somali female group: pg. 28-29/ lines 557-560)

The Bangladeshi and Somali female groups also discussed gender and tradition based negative community smoking attitudes. For example, these involved the Bangladeshi

community viewing female smoking in a negative light as a result of traditional smoking genders norms, which was a barrier when smoking in public areas. For example, Priya from the Bangladeshi female group highlighted how there was a discrepancy in reaction towards male and female smoking by the Bangladeshi community due to differing expectations regarding the genders.

> "Like when a Bengali person sees a boy smoke it's like 'oh it's ok at least he's not doing anything else', you know. 'He's smoking but at least he's not smoking weed' even when half the time he probably is as well but obviously they don't know that and it's like 'ah it's ok, he's a boy, he can smoke you know'. It's like they've got nothing to live up to. But when they, if a Bengali person saw a Bengali girl smoke then ohhh myy god!" (Priya, Bangladeshi female group: pg. 25/ lines 588-592)

Risk of parental disclosure via the community as a barrier to location was discussed by all of the female groups and the Somali male group. This was a barrier to smoking in public places and involved community informants reporting smoking behaviour to parents.

> Ayan: They'll [community members] tell your parents.
>
> Nadifa: Definitely.
>
> Amina: Straight away.
>
> Xaali: Before you go home, your mum will know.
>
> I: Really?
>
> Nadifa: Yea, you'll walk in through the door it will be like what were you doing today, someone told me this.
>
> I: Really.
>
> Nadifa: Yea, it's like BBC news! A -Class BBC news, it's A-Class. It's like they've got CCTV on their bodies! CCTV bodies!

> Amina: They see you. I was bunking off once yea and the next time I came home yea they were like what were you doing today and I was like who even told you?!
>
> (Somali female group: pg. 47/ lines 918-929)

The Somali male group discussed how reporting to parents was often exaggerated and used as a way of conducting 'one-up-man ship' against each other:

> Dalmar: It's the mother's friends. I'm telling you! Your son smokes, you son smokes and actually smokes crack as well...
>
> Taban: Yeah they add their little extras, it's like Chinese Whispers.
>
> Dalmar: They make up stories.
>
> Roble: The BBC Somali Media.
>
> All laugh
>
> Taban: So it's basically like who had the best kids innit like. 'My son this, my son that but your son smokes and this and that'.
>
> (Somali male group: pg. 11/ lines 288- 295)

The Bangladeshi female group also spoke about the negative parental reaction from discovering via the community, which consisted of feelings of shame, upset, anger and protestations at having discovered second-hand.

> "I've had like lots of people talk about me and then they go back to my mum and then my mum'll get upset and she'll start fighting with me." (Anjali, Bangladeshi female group: pg. 64/ lines 1460-1461)

Risk of community discovery per se was a barrier to smoking publicly for the Somali female and Bangladeshi male group. This was due to parental instruction not to be discovered by the

community and desire not to be discovered by the local community when smoking past the mosque due to it being disrespectful. For example, Deeqa from the Somali female group mentioned how her mother had accepted her smoking but advised her not to be seen by the community:

> "And then she just spoke to me about it and then told me 'just don't let people see'. Like 'I know, I'm your mum and I'll cover for you but not let other people know'." (Deeqa, pg. 20/ lines 383-385)

Finally, community barriers to general smoking behaviour consisted of negative smoking attitudes held by teachers at participants' educational establishments. The White British male and Somali female groups described teachers' encouragement for cessation and protestation towards effects on their hygiene:

> "Our teacher asked us if we smoke umm when we first enrolled, I said no because that time I wasn't, like I had stopped smoking but then a couple of days after that's when I started and then she asked me. Once I walked through the class and she went * have you been smoking? And she goes 'that's very bad you shouldn't have started again'..." (Deeqa, Somali female group: pg. 48-49/ lines 954-957)

> "I used to get that all the time in secondary school; I used to come back in, 'oh you been smoking? Change your blazer it stinks of smoke' and I'm like 'I can't smell it'." (Robert, White British male group: pg. 20/ lines 579-580)

iii) Peer barriers impacted on participants' general smoking behaviour and their disclosure of smoking behaviour. Peer barriers impacting on general smoking behaviour included psychological rejection of participants' smoking behaviour, which was mentioned

by the Somali and Bangladeshi female groups. This firstly consisted of behavioural rejection which involved non-smoking peers chastising the smoking behaviour, lecturing on negative effects of smoking and attempting to encourage cessation:

> "Actually the non-smokers around me think my smoking's disgusting. Umm. 'Why do you do it? Why?...You're wasting so much money, you know you're gonna end up looking like you're 60 when you're 30'. You know all this stuff." (Sanchita, Bangladeshi female group: pg. 91/ lines 2058-2061)

> "Yea they [peers] look after you as well they say to you sister it's not good for you, you shouldn't smoke..." (Nadifa, Somali female group: pg. 50/ lines 977-978)

Peer psychological rejection also involved non-smoking peers having negative attitudes and images of smoking which were mentioned by the Somali female and Bangladeshi female groups. Negative smoking attitudes held by peers were mentioned by the Somali female group and consisted of negative smoking attitudes held by other young non-smoking Somali males. For example, Nadifa described how these attitudes thwarted prospects of future partnerships with these males and also expressed that these negative attitudes were levelled at both male and female smokers so there were not any double-standards.

> "Most boys, ok some of them say I'm not smoking cos they're into their football whatever and they're not gonna want a girl to smoke cos it's going to affect them...Yea either the boy smokes or the girl smokes, it's the same thing." (Nadifa, Somali female group: pg. 49-50/ lines 962-997)

Negative smoking images held by peers was mentioned by the Bangladeshi female group. For example, Mala described being viewed as a bad person by her former non-smoking school peers for smoking.

> Mala: I'm in college right now but when I was in secondary school, it wasn't that long ago, people used to go on at me and think I was really bad. Even now if I go to school and they see a cigarette in my hand they will stop and they will stare and they will think it's like me holding I dunno a knife or something.
>
> Others laugh
>
> Mala: They find it like so weird. I remember like last, two weeks ago I must have entered my secondary to go and get a reference and they were like staring at me and they just looked at me and gave me this massive dirty stare. They said to me before you've changed, we thought you were so good.
>
> (Bangladeshi female group: pg. 20/ lines 476-484)

Peer psychological rejection based on tradition and gender was discussed by the Bangladeshi female group and involved young Bangladeshi males regardless of their own smoking status having a negative image of and negative attitude towards female smokers. This was due to their defiance of traditional smoking gender norms and breaking traditional ideals of femininity. This rejection was encountered in friendships as well as in potential partnerships.

> "I think they want to see girls as pure and cigarettes you know demolishes that."
>
> (Bharati, Bangladeshi female group: pg. 32/ line 747)

> "Yea when I met guys before. Being Bangladeshi or Asian or being Asian period and being a girl if you smoke you are viewed as cheap and just basically trash. That's

point blank. But if a guy does it it's fine." (Sanchita, Bangladeshi female group: pg. 25/ lines 593-595)

Dipika: You can't be hypocritical innit. I know some of them try to be like that.

Priya: They try to be yea.

I: They do try?

Priya: Like my friends, one or two times, they're like why do you do it, you know? And...

Dipika: Well they've still got a cigarette in their hand!

(Bangladeshi female group: pg. 31/ lines 736-740)

Next, peer barriers impacted on disclosure of smoking behaviour which was mentioned by the Somali female group and involved protection of peers' feelings. Deeqa from the Somali female group mentioned not wishing to disclose her smoking behaviour to her peer after having relapsed, to avoid him feeling disappointed in her:

"...but then in a way like I didn't want him to be disappointed...." (Deeqa, Somali female group: pg. 50/ line 991-992)

iv) Finally, religious barriers impacted on accessing cigarettes, location of smoking and general smoking behaviour. The Somali female group discussed impact on access and location which involved the barrier of wearing of religious garb. This was a barrier when asking strangers in the street for cigarettes and when smoking in public places, due to inciting negative reaction from the Muslim community:

"Cos a lot of us we started smoking before putting our headscarf or before we started covering so then now that we're addicted and now that we started covering up it's even more harder." (Ayan, Somali female group: pg. 36-37/ lines 714-731)

"Only thing I've realised cos she [Deeqa] wears a scarf...cos on the streets obviously people are going to see you, if they're the same religion they're gonna think this girl's bad, she's giving Muslims a bad name..." (Nadifa, Somali female group: pg. 46/ lines 903-905)

All of the groups except for the White British groups discussed religious barriers to general smoking behaviour, which involved undergoing smoking abstinence for Ramadan. This involved attempting to observe the daily fast or abstaining for the whole month. The Somali and male group mentioned abstaining for the full month. For example, Ghedi from the Somali group mentioned quitting for the whole month before reverting back to smoking:

Ghedi: I just stopped for the holy month.

I: Just for the holy month?

Ghedi: Yea I stop for the month then I'm straight back in there.

(Somali male group: pg. 27/ lines 670-672)

Participants from the Bangladeshi male and Somali female group discussed managing to observe the daily fast but participants from the Bangladeshi male, Somali female and Bangladeshi female groups also described failure at attempts to observe the daily fast.

"I stop in Ramadan, I don't know how I do it but I smoke after I finish eating so..."

(Ayan, Somali female group: pg. 30/ line 584)

Zahir: Yea, who smokes while they're fasting?

Adan: I did.

Hasan: I did it.

Ismail: I did it a few times.

Adan: I do it a few times yeah. I just, fuck it.

(Bangladeshi male group: pg. 13/ lines 337-342)

3.4.1.1.3. Financial barriers

All of the groups described having difficulties in accessing cigarettes due to being short of money. For example, the Somali male group stated:

Roble: Yeah I've had problems getting hold of cigarettes.

Dalmar: Just when you're short of cash.

Abdi: Yea sometimes.

(Somali male group: pg. 22/ lines 557-559)

3.4.1.1.4. Psychological barriers

Psychological barriers to smoking freedom were described by all of the focus group and consisted of experiencing negative affect over smoking behaviour and having beliefs based on age, tradition and gender that limited smoking in the presence of others and disclosing smoking behaviour to others.

Firstly, negative affect over smoking behaviour resulted from socio-cultural barriers to smoking and concealment of smoking from parents. Negative affect arising from socio-cultural barriers was described by all of groups and included experiencing negative emotions of fear, worry, upset and shame.

Mala:...my mum is one of them ones where she knows how to fight. She's this small (gestures).

Others laugh

Mala: She can somehow, I don't understand, in two minutes I'm on the floor.

I: Really?

Mala: Yea (laughs). She is mad so I was scared like of her...

(Bangladeshi female group: pg. 29-30/ lines 693-698)

"Most people worry about it, you don't want em [parents] to know." (Ghedi, Somali male group: pg. 17/ line 438)

"...so I felt bad when he [dad] found out." (Robert, White British male group: pg. 6/ line 176)

The Somali female group discussed experiencing negative affect as a result of concealing their smoking behaviour from parents. This included feeling bad and sorry:

"...but then I felt bad like oh shit, I'm lying to my mum, I don't like lying to my mum." (Deeqa, Somali female group: pg. 24/ line 464)

Next, having beliefs based on age, tradition and gender that limited smoking in the presence of others and disclosing smoking behaviour to others, was discussed by all of the groups except the White British female group. Firstly, with regards to beliefs based on age, the White British male group described having beliefs of it being disrespectful to smoke in front of parents due to the parent-child relationship.

I: So you can't smoke in front of your parents? Why do you think that is?

Liam: Disrespectful.

Sean: Yea it's disrespectful.

I: Yea? Is that what you feel?

Liam: My mum don't wanna see her kid smoking cancer sticks.

(White British male group: pg. 6-7/ lines 179-184)

Beliefs based on a combination of tradition and age, were mentioned by all of the groups aside from the White British groups. These involved having beliefs in line with traditional norms regarding the unacceptability of youth smoking whereby it was deemed disrespectful for young smokers to smoke in front of family and community members, regardless of the others' smoking status. The Bangladeshi male and female group perceived this to be a cultural difference between Asian and White people:

Salman: White people yeah they can smoke in front of their parents because they you know they got different errr...

Adan: Views.

Salman: ...views and that innit.

I: Right.

Salman: So with Asians like it's different innit.

I: Yeah yeah.

Salman: There's more respect with Asians innit.

Hasan: It's not just parents, anyone in the streets.

Salman: Yea, it looks bad.

(Bangladeshi male group: pg. 17-18/ lines 439-448)

The Somali male group outlined the temporary nature of the situation, outlining how this was only applicable when they were younger and would change when they grew older and had their own families. Also the Bangladeshi female group mentioned feeling disrespectful when they smoked in front of family members despite their awareness and permission to smoke and despite engaging in other substance use in front of them:

> Dipika: My older cousin brother he doesn't really mind but I just feel weird doing it.
>
> Priya: Yea.
>
> Dipika: I won't touch it, I'll do shisha with him, I've done that a few times with him but I won't touch a cigarette.
>
> Priya: It's that respect innit? It's like there's a limit to how comfortable you feel. Two weeks ago I went to my uncle's house and I had like a full box on me and everything and I was with them the whole day and he knows I smoke. I mean when I'm in his house he will let me just go into their garden and just have a cigarette and stuff and on that day, I don't know why, I thought hold on I'm taking liberties here, like you know. I thought to myself it's wrong that I do that.
>
> Dipika: I don't smoke down there either!
>
> (Others laugh)
>
> (Bangladeshi female group: pg. 43-44/ lines 997-1017)

Beliefs based on tradition and gender, were discussed by the Bangladeshi and Somali female group, which involved reluctance to smoke in front of young Asian males due to beliefs on gender cultural norms regarding smoking. This resulted in feeling disrespectful or fearing negative judgment as a female smoker when defying traditional smoking gender norms. For example, Sanchita from the Bangladeshi female group describes how she was initially

reluctant and uncertain to smoke in front of a male peer due to being perceived negatively, despite being offered a cigarette from him.

> "Yes (laughs) but erm yeah at the beginning I was a little bit reluctant to smoke in front of him as he'd think I was bad, I wasn't too sure whether to take it or not..." (Sanchita, Bangladeshi female group: pg. 26/ lines 608-609)

These beliefs in traditional smoking gender norms were also a barrier to disclosure of smoking to family members. Dipika from the Bangladeshi smoke commented how she would never disclose her smoking behaviour to her male cousin as it went against traditional smoking gender norms:

> "I would never do that. I couldn't tell my cousin, I'm a girl!" (Dipika, Bangladeshi female group: pg. 43/ line 993)

Overall it can be seen how there are such a range of barriers that impact on the smoking freedom of the participants. These barriers are both external and internal, which are dictated by societal norms regarding smoking behaviour. Through encountering these barriers, the reality of the smoking world is being negotiated by participants.

3.4.1.2. Facilitators to smoking freedom

All of the groups described facilitators to their smoking freedom. These included legal and socio-cultural facilitators to their smoking freedom.

3.4.1.2.1. Legal facilitators

Legal facilitators to smoking freedom were discussed by all of the groups and consisted of facilitators to accessing cigarettes. These involved lack of enforcement of the tobacco purchase age legislation by shopkeepers and being able to purchase cigarettes, which

was in part attributed to participants' appearance of looking older and acquiring the right dress code:

Robert: Oh well I still got served when I was 15.

Liam: I get served everywhere.

Sean: I get served loads of places.

Liam: Yea, I get served in most places.

(White British male group: pg. 11-12 /lines 332-335)

"Nowadays a lot of girls look older yea they are because of the like, like dress sense and the makeup and you know this and that, so it's getting harder for shopkeepers to tell." (Priya, Bangladeshi female group: pg. 41/ lines 959-960)

3.4.1.2.2. Socio-cultural facilitators

All of the groups discussed socio-cultural facilitators to their smoking freedom. These included i) socio-cultural facilitators to accessing cigarettes ii) the location in which participants' smoked iii) their general smoking behaviour and iv) disclosure of their smoking behaviour to others.

i) Socio-cultural facilitators to accessing cigarettes comprised of others providing access to cigarettes, which was mentioned by all of the groups. This included via sharing of cigarettes, purchasing of cigarettes, provision of spares and allowing theft of supplies. Firstly, with regards to sharing cigarettes with peers, this was a process often described as 'twosing', and was mentioned by all of the female groups. Next, the Somali male, White British male and Bangladeshi female group mentioned how family members, such as parents and cousins, and strangers, would purchase cigarettes for them or provide money for cigarettes.

Robert: No I have to earn it, I have to do housework for fags.

I: Really?

Robert: Yea if I do a bit of housework my mum would say alright I'll buy you 10 fags if you do this and you do that, so she never just buys me them.

David: My mum does – ha ha!

(White British male group: pg. 13/ lines 376-379)

Provision of spares was mentioned by all the groups except the Bangladeshi male and Somali male group and involved obtaining spares from family members, peers and strangers (this also included being offered cigarettes by others without request).

"No if I really need a cigarette then I'll ask my mate for one or two or something but if I don't need one then I just won't have one." (Lisa, White British female group: pg. 23/ lines 553-554)

Finally, with regards to allowing theft of supplies, Bharati from the Bangladeshi female group mentioned that her mother allowed her to steal her cigarettes without challenge.

"...she [mother] doesn't say nothing and I do take her cigarettes all the time and obviously she notices it but she doesn't say nuthin about it." (Bharati, Bangladeshi female group: pg. 24/ lines 572-573)

ii) Socio-cultural facilitators to location of smoking were discussed by all of the groups except the Bangladeshi male and White British female groups. These included familial, religious and community facilitators. Familial facilitators included parental awareness of smoking behaviour, permission to smoke in location, having a friend-like relationship with family members and non-Asian ethnicity of family members. With regards

to parental awareness this was stated by both the Somali groups, which resulted in being able to smoke in public locations without fear of parental discovery:

> "But with me it's like now I think cos my parents know that I smoke I don't mind where I smoke, I'll smoke anywhere, so if any people see me it doesn't matter." (Nadifa, Somali female group: pg. 46/ lines 911-912)

Parental permission to smoke at home was mentioned by the White British male and Somali female group.

> "I can, I can smoke in the kitchen...My mum don't care." (Robert, White British male group: pg. 6/ lines 178-183)

Having a friend-like relationship with family member was mentioned by the Bangladeshi female group. Dipika described how she would smoke in front of family despite traditional norms regarding respect, because their relationship was more 'friend-like' and Priya outlined how this would only be applicable to smoking behaviour and not other substance use.

> "But I do smoke with my sister and my aunty because they well they seem like friends." (Dipika, Bangladeshi female group: pg. 32/ line 767)

> "I don't really smoke weed or anything. I don't. I've never touched it and I've never really touched alcohol or anything, but just say if I was to. Just because I can smoke in front of her [cousin sister] doesn't mean to say that I would actually smoke weed in front of her because that's a completely different thing. Do you know what I mean?...They're proper far apart." (Priya, Bangladeshi female group: pg. 33/ lines 787-794)

With regards to non-Asian family members, Sanchita from the Bangladeshi female group mentioned how she smokes in the presence of her partner because he is not Asian:

> "Because he's a completely different culture, he's not Asian. It's more like an OK thing, whatever goes, you know." (Sanchita, Bangladeshi female group: pg. 74/ lines 1678-1679)

Next, with regards to religious facilitators, Nadifa from the Somali female group described how she was able to smoke more publicly than her peers due to lack of religious garb:

> "But with me cos I don't cover up and stuff I find it normal to smoke anywhere..." (Nadifa, Somali female group: pg. 46/ lines 905-906)

Finally, with regards to community facilitators the Bangladeshi female group discussed how teachers' acceptance of their smoking behaviour made them comfortable about smoking outside the college:

> "At college some of the teachers smoke with us so it doesn't really bother us smoking there." (Anjali, Bangladeshi female group: pg. 23/ line 537)

iii) Socio-cultural facilitators to general smoking behaviour were discussed by all the groups and included peer acceptance and familial facilitators. Peer acceptance was discussed by the Somali and Bangladeshi female groups, which consisted of acceptance by smoking peers and non-smoking peers. With regards to acceptance by smoking peers, Nadifa from the Somali female group described the acceptance of her smoking behaviour by young Somali male smokers that she was in a relationship with. She spoke of how their smoking status allowed her smoking freedom in the relationship.

> "...but then if you have a boyfriend who smokes and you smoke you think, you feel happy like cos most boys wouldn't want you to smoke, wouldn't want their girlfriend to smoke but then if he smokes as well then it's ok cos you won't be hiding it from him."(Nadifa, Somali female group: pg. 49/ lines 964-967)

The Bangladeshi female group discussed how their Bangladeshi male smoking peers were empathetic and more liberal towards their smoking behaviour than the non-smokers, although their intentions were questioned.

> Priya: Noo not really for me, anyway I dunno maybe for you but like my friends they love the fact that I smoke. Like my boy mates and stuff, they're all my age and I've got like one or two younger and stuff like that, but err because the only reason why they love the fact that I smoke is because obviously if they don't have cigarettes who do they come to ?! Cos you know I'm not very stingy with my cigarettes either you know so...
>
> Dipika: They're more, more liberal.
>
> Priya: Yea they kind of understand and stuff.
>
> (Bangladeshi female group: pg. 31/ lines 729-735)

The Somali female group also discussed acceptance by their Somali male smoking peers, despite smoking being against their religion. However, they felt this was a given as otherwise it would be deemed hypocritical. From a more general perspective regarding smoking peers, Mala from the Bangladeshi female group described how none of her college smoking peers had instructed cessation.

> "What I realised yea that when I come to, when I came to this college no one's ever told me to stop cos erm the majority of the people that I, that I jam with they smoke..." (Mala, Bangladeshi female group: pg. 20/ lines 470-471)

With regards to acceptance of smoking by non-smoking peers, the Bangladeshi female group described gradual acceptance due to the futility of their requests for cessation:

> Priya...even my close friends have realised not to kind of bug me too much. Yea they just leave it cos they...
>
> Dipika: They give up in the end (all laugh).
>
> Priya: Yea I think they realise to a certain point where, ok it's going in one ear and out the other and she's clever enough to know when to stop kind of thing.
>
> (Bangladeshi female group: pg. 19/ lines 447-451

Next, familial facilitators were discussed by all of the groups, which included familial acceptance of smoking, lack of familial confrontation and lack of familial retribution over smoking. Familial acceptance of smoking involved actual and anticipated acceptance and was mentioned by the Somali male, White British male, Somali female and Bangladeshi female groups.

> "My dad isn't bothered at all, he said well if you want to do that then you can do that, it's your life but I don't live with him so..." (Sean, White British male group: pg.7/ lines 194-195)

With regards to lack of familial confrontation, this involved lack of parental acknowledgment of smoking behaviour, despite participants' having suspicion of their awareness. This was expressed by both the Bangladeshi groups and the White British female group.

> "For me, they didn't really say nothing but they, she [mother] could just smell it on me. Saw my pack you know. But she really didn't say nothing..." (Adan, Bangladeshi male group: pg. 17/ lines 422-423)

Lack of familial retribution over smoking behaviour involved an actual or anticipated lack of familial retribution, and in part resulted from family members' own smoking behaviour. This was mentioned by the White British male and Bangladeshi female groups:

> "That's what I mean when I first started smoking I just thought that my mum smokes and you know she can't really say much cos she smokes..." (Sean, White British male group: pg. 5/ lines 147-148)

iv) Socio-cultural facilitators to disclosure of smoking behaviour were discussed by both Bangladeshi and Somali groups and consisted of lack of parental retribution, religious beliefs and belief in inevitability of parental discovery. Firstly, with regards to lack of parental retribution, Sanchita from the Bangladeshi female group spoke of how she waited until she was older to disclose her smoking to her mother as she was less strict then.

> "And it was like because you know you're in an Asian household, everybody knows traditional Asian families are, well you know the rules are strict. But I think, as I've got older they relaxed so like my mum knows I smoke now."(Sanchita, Bangladeshi female group: pg. 34/ lines 801-803)

Next, with regards to religious beliefs, Abdi from the Somali male group discussed the irrationality of concealing his smoking from his parents but not his God. As a result he believed concealment was wrong and disclosed to his parents.

Abdi: It's bad to hide though, like you smoke at the end of the day, you shouldn't hide it from your parents...We're Muslim yeah...like if we're going to hide it from our parents but not hide it from our God that don't make sense does it?

I: Ok right hmm.

Abdi: You can hide it from your mum but God can always see you and that. He's looking upon you at all times.

I: So your parents are aware of it?

Abdi: So I'm not gonna lie, I'm not gonna lie. I tell my parents.

(Abdi, Somali male group: pg. 10/ lines 259-273)

Finally, the Bangladeshi male group discussed their beliefs in the inevitability of parental discovery, which was the catalyst for their parental disclosure.

Salman: One day they'll catch you man. What's the point?

Zahir: Yea they're going to catch you anyway. If you smoke you're gonna get caught.

Adan: Yea it's not something you can hide cos you're gonna start smelling and get caught.

(Bangladeshi male group: pg. 17/ lines 427-429)

Overall it is apparent that there a range of facilitators that originate from the social world and assist participants to reside in the smoking world. These can help to overcome the barriers discussed earlier and provide validation for participants in asserting smoking behaviour as an accepted behaviour.

3.4.1.3. Reclaiming smoking freedom

All of the focus groups illustrated attempts to reclaim their freedom to smoke. This involved rejecting barriers to smoking freedom which consisted of rejection of legal and socio-cultural barriers.

3.4.1.3.1. Rejection of legal barriers

All of the groups illustrated rejection of legal barriers to smoking. This consisted of rejection of legal barriers to i) access and ii) location of smoking.

i) Rejection of legal barriers to access was discussed by all of the groups except the Bangladeshi male group and consisted of psychological rejection. Firstly, this psychological rejection involved behavioural rejection of legal barriers to access, which was expressed by the Somali male, Bangladeshi female and White British female groups. This consisted of displaying confrontational behaviour, avoidance behaviour and seeking alternative means to access. Confrontational behaviour was displayed against shopkeepers when being refused access to cigarettes and was mentioned by the Somali male group and the Bangladeshi female group. This included swearing, demanding cigarettes, refusing to leave the shop premises, and protesting at the decision:

> "I was like fuck you just give me my cigarettes [to shopkeeper]....I was like shut up man don't chat shit." (Anjali, Bangladeshi female group: pg. 93-94/ lines 2108-2110)

Avoidance behaviour was described by the White British female and Bangladeshi female group in relation to the graphic images on boxes. They described not looking at the images when accessing the cigarettes:

> "We're not really looking at the box when we go to smoke a cigarette. We're just going to take one out and spark it." (Claire, White British female group: pg. 10/ lines 212-220)

Seeking alternative means to access was mentioned by the Somali male and Bangladeshi female group and this consisted of asking strangers on the street or family members to purchase cigarettes when being denied access from shops:

> "Do you know what I do when I am in that position I go outside the shop and I'll wait for someone to walk by. I'll say 'excuse me could you buy me fags, I ain't got my ID'." (Roble, Somali male group: pg. 22/ lines 547-549)

Psychological rejection towards legal barriers to access also included having negative feelings, beliefs and attitudes towards the tobacco purchase age law, graphic images being displayed on cigarette boxes and the proposed future law of concealing cigarettes from shop displays. This was displayed by all the groups except the Bangladeshi male and White British female groups. Firstly, negative feelings involved feelings of annoyance and anger towards the age law and graphic images. The White male group described annoyance when the tobacco purchase age was raised. The Bangladeshi female group described anger over having to produce ID when purchasing cigarettes and the Somali male group displayed anger towards graphic images on boxes due to beliefs in the government's disingenuous motive behind the measure:

> Abdi: You see a guy dying on a box; it says smoking will kill you if you do not stop. But it's too late to do that.
>
> Roble: But why are they selling it?
>
> Abdi: Yea they're selling it but why do that?
>
> I: Ok.
>
> Dalmar: Yeah I know why. A few years ago some woman sued some cigarette company for that innit. And they didn't give no warning about what a cigarette does

to you so that woman got a lot of money so since that day they've started doing all these things, you get me?

I: Ok.

Roble: Plus the government makes money out of it.

Taban: The government don't care about you basically! At the end of the day they're making their money they don't care.

Roble: Yea they don't care; they're just worried about the dough.

(Somali male group: pg. 24/ lines 585-606)

Next, with regards to negative beliefs, the Somali female and Bangladeshi female groups spoke about beliefs in the ineffectiveness of such measures:

Priya:...like I heard that they were gonna come up with this law where they're gonna actually hide the cigarettes, behind the counter or something?

I: Yea?

Priya: That's so ridiculous.

Others laugh

Priya: It's so stupid, ooh you're not gonna see it, so ooh now you're not gonna want a cigarette, it doesn't make sense. If you're gonna come up with a regulation like that make it have sense.

(Bangladeshi female group: pg. 94/ lines 2113-2120)

Finally, the White British male showed negative attitudes towards the laws describing them as pathetic.

> "Yea I think the smoking law is pathetic yea because you gotta be like 18 to buy cigarettes but you can smoke them in the street at whatever age." (David, White British male group: pg. 11/ lines 320-321)

ii) Rejection of legal barriers to location was discussed by all of the groups and consisted of psychological rejection. This psychological rejection firstly comprised of behavioural rejection which was displayed by the Bangladeshi female and White British male groups. This involved displaying challenging behaviour towards the smokefree public places legislation and smoking on public transport ban by flouting both laws.

> Bharati: Yea I still smoke in public places like if I have a cigarette and I'm going into McDonalds or something I wouldn't like stop smoking, I'll carry on smoking and like if they tell me to stop I wouldn't and stuff and sometimes I get kicked out and stuff.
>
> I: Do you?
>
> Bharati: Yea but I don't really care.
>
> I: How does that make you feel, when you get kicked out?
>
> Bharati: I dunno, it's funny but it's like fine for my friends cos we start cussing the people and stuff and it's just funny.
>
> (Bangladeshi female group: pg. 94/ lines 2123-2130)

> David: We'll just have a fag where we fancy it, whenever we fancy it, we could be at a bus stop, we could have a fag, we could be just out walking to the shops, anywhere really.
>
> I: Really?
>
> All: Yea.

Sean: I even smoke where I'm not supposed to smoke...in the train stations, wherever there is a sign I'll smoke.

(White British male group: pg. 24/ lines 717-723)

Psychological rejection towards legal barriers to location also involved having negative feelings and attitudes towards the barriers which were expressed by all of the groups. Negative feelings consisted of annoyance and anger resulting from the smoking in public places legislation:

Priya: But you don't understand man, I have to go into blocks and stuff you know.

Mala: I know it pisses you off when you're really cold.

(Bangladeshi female group: pg. 98/ lines 2197-2198)

Negative attitudes involved disagreement with not being able to smoke on public transport and not being able to smoke in enclosed public places. Some of these attitudes stemmed from beliefs in the ineffectiveness of the measures.

Deeqa: ...I don't agree with the law cos they're trying to say they don't want the cigarette to affect other people but then either way if you're smoking outside it's gonna affect people as well so it makes no difference like.

I: Ok.

Hawiiya: It don't make a difference if you're in public or not cos it's gonna be the same, it's gonna affect everyone.

(Somali female group: pg. 66/ lines 1302-1307)

Negative attitudes were also aimed at possible future legal barriers to location of smoking including smoke free cars and a total public places ban, but the unfeasibility of such measures was also discussed, which mainly involved corporate and government profiteering:

> David: Innit, I see loads of people that are still on their phones. They can't stop smoking in a car, that's like trying to say you can't smoke in your own house.
>
> Sean: Yea you can't smoke in your own house. It's your car, you paid for the car.
>
> David: If they really wanted everyone to stop smoking yea they should stop selling fags.
>
> Sean: Yea but they're not allowed to do that, that's why they haven't done that.
>
> I: Why do you think they're not allowed to do that?
>
> Sean: Cos it's everybody own choice if they want to do it or not and obviously the company that's selling it and peoples that are trying to stop people from smoking they can't exactly like obviously tell them 'no, you gotta stop selling cigarettes'.
>
> (White British male group: pg. 18/ lines 526-540)

> Adan: ...but if they completely stopped smoking, nah man I wouldn't like that...
>
> Zahir: They can't. They need the money.
>
> Hasan: Yea.
>
> Ismail: Taxes.
>
> Zahir: The tax!
>
> Adan: Plus there's so many companies that make cigarettes. They need their business, they need their money.
>
> (Bangladeshi male group: pg. 26/ lines 651-658)

3.4.1.3.2. Rejection of socio-cultural barriers

All of the groups demonstrated rejection of socio-cultural barriers to smoking, which consisted of rejection of socio-cultural barriers to i) access ii) location and iii) general smoking behaviour.

i)Rejection of socio-cultural barriers to access was described by the Somali female group and this consisted of psychological rejection. This psychological rejection firstly involved behavioural rejection, which comprised of seeking alternative means to access when encountering negative community attitudes:

> "Yea, that's like me I'll buy my own box, once I went up to somebody 'oh can I have a cigarette, excuse me or whatever' but now it's like if I get money I'll buy my own cigarettes, in the past was relying on people."(Nadifa, Somali female group: pg. 35/ lines 688-690)

It also involved having negative feelings, such as annoyance and anger when being refused access to cigarettes from stranger on the street due to their age, which strengthened resolve to smoke:

> Nadifa: They say 'aren't you young', when they say 'no' to me I get so angry I wanna hit them.
>
> Ayan: I get annoyed...
>
> (Somali female group: pg. 36/ lines 701-705)

> Ayan: ...I'm just like I'm gonna carry on smoking.
>
> Nadifa: Me too.
>
> Xaali: Well when people say yea you're too young to smoke, you should stop smoking and they're smoking themselves.
>
> All: They're hypocrites.

(Somali female group: pg. 36/ lines 705-709)

ii) Rejection of socio-cultural barriers to location was discussed by all of the groups except the White British male group. This comprised of psychological rejection, which firstly involved behavioural rejection. This was expressed by all the groups except the White British male group and consisted of taking cautionary measures and denial of smoking status. Taking cautionary measures was done in public locations to prevent community and/or parental discovery and at home to prevent parental discovery of smoking behaviour, which was mentioned by all the groups except the White British male group:

Taban: Basically there is a place like you hang out, you can sit and you can see your house but your house can't see you.

I: Ok.

Taban: So basically you can see whose coming in and out – you can see your parents walking out or going in.

Roble: But they can't see you.

Dalmar: So you can just have a fag.

(Somali male group: pg. 18/ lines 462-468)

Cautionary measures in public locations included smoking in concealed areas and hiding cigarettes and at home included engaging in avoidant behaviour and disguising of smoke:

"When you gotta walk past the mosque you just put the cigarette to the side, hide it, so when you walk past they don't see." (Hasan, Bangladeshi male group: pg. 18/ lines 449-450)

"...so I have it when I go into the bath...before I get in the bath I'll have a cigarette out the window..." (Priya, Bangladeshi female group: pg. 16/ lines 386-389)

Finally, denial of smoking status was in response to parental discovery via community disclosure.

Dalmar: That's what I'll say to my mum, 'mum she's lying.'

Ghedi: I say 'she's an old lady, she's an old lady, she's lying.'

Dalmar: Yea.

Roble: She's a liar.

(Somali male group: pg. 18/ lines 449-452)

Psychological rejection also involved the Somali female group expressing disregard for negative community smoking attitudes over time.

Ayan: We're used to it now.

Nadifa: We're used to it now, with me especially I don't care no more.

Xaali: Yea.

Ayan: Yea, I don't care.

(Somali female group: pg. 47-48/ lines 932-935)

iii) Rejection of socio-cultural barriers to general smoking behaviour was discussed by all of the groups and consisted of psychological rejection of barriers. This firstly involved behavioural rejection, which was described by all of the groups. This consisted of deceit over smoking status, concealment of smoking behaviour, challenging behaviour and dismissive behaviour. Deceit over smoking status was aimed at both peers and parents:

> "My mum said have you quit and I said yea I quit." (Melanie, White British female group: pg. 19/ line 448)

Concealment of smoking behaviour consisted of hiding smoking behaviour from parents which included not smoking in front of them and concealing signs of smoking:

> Taban: Bust a bunch of chewing gums in your mouth before you go in.
>
> I: Is that what you do?
>
> Ghedi: I just got the Lynx out man.
>
> Roble: I would do that with my parents all the time man [indicates spray action], do that when you go in.
>
> (Somali male group: pg. 10/ lines 253-257)

Challenging behaviour consisted of verbal and physical challenging behaviour. Verbal challenges were directed at perceived hypocritical attitudes held by peers and family members and at familial negative image of smokers:

> "They all smoke shisha so then when my mum is telling me 'ah don't smoke cigarettes' I'm like to her 'well you do something about it too' [laughs]." (Dipika, Bangladeshi female group: pg. 84/ lines 1900-1901)

Physical challenges consisted of physical confrontation of community members due to threats of parental disclosure.

Finally, dismissive behaviour was directed at peer and familial attempts at cessation.

> "It made me smoke more, cos of my mum, to piss her off." (Jack, White British male group: pg. 6/ line 166)

Psychological rejection of socio-cultural barriers to smoking also comprised of negative feelings and defiant attitudes and beliefs towards community, familial and peer barriers to smoking. This was displayed by all the groups except the Bangladeshi male group. Firstly, negative feelings consisted of anger at parental disclosure via community informants and feelings of annoyance towards peers' questioning of smoking behaviour:

> Dipika: But I find non-smokers slightly annoying- they don't understand!
>
> All laugh
>
> Priya: Yea.
>
> I: Ok.
>
> Mala: And when you're craving for a cigarette and they piss you off, and I'm really craving for one and they're like 'why are you smoking, why are you smoking for?'
>
> Dipika: They don't understand.
>
> Mala: And I really want a cigarette and they're telling me 'why are you smoking, why are you smoking?' I want a cigarette and you're just in my ear, going 'yap yap yap'.
>
> (Bangladeshi female group: pg. 92/ lines 2077-2085)

Next, defiant attitudes consisting of disregard and disagreement were aimed towards community, peer and familial rejection of smoking behaviour. Disregard was aimed at teachers' anti-smoking attitudes, parental physical retribution, anti-female smoking attitudes of Bangladeshi males and anti-smoking attitudes of the community.

> Robert: I dunno. To be honest I didn't really care. I mean I probably knew I smelt of smoke but it just didn't bother me.
>
> Jack: Cos it's only teachers innit. (laughs)
>
> Robert: It's only teachers innit.

(White British male group: pg. 20/ lines 582-585)

Disagreement involved disagreement with non-smoking peers' negative smoking attitudes, parents' negative image of female smokers and Bangladeshi male peers' anti-female smoking attitudes. Finally, defiant beliefs consisted of beliefs in hypocrisy regarding smoking parents' actual or anticipated anti-smoking attitudes:

Melanie: No, I'm not gonna lie our parents are kind of hypocrites if they smoke as well. Especially when they're smoking themselves and they smoke more cigarettes than we can ever have.

Tina: My mum and dad can't chat. My dad started when he was 10 and my mum started when she was 11 so they can like get out of the picture.

Melanie: My mum was like 19 and my dad started at 15.

(White British female group: pg. 20/ lines 462-467)

3.4.1.3.3. Rejection of financial barriers

Rejection of financial barriers consisted of sourcing cheaper cigarettes, seeking monetary assistance from family members, seeking alternative means to access, or smoking roll-ups and was stated by all of the groups. Firstly, with regards to sourcing cheaper cigarettes, this included looking in alternative shops for cheaper cigarettes or bulk buying cigarettes from abroad. The Bangladeshi male group remarked on the ease of access to cigarettes due to the prevalent supply abroad and the White British female group mentioned how, although they purchased cigarettes from street vendors abroad, they would not do this in England, which was a sentiment echoed by the Bangladeshi male group:

I: Oh ok. So you said you never found it difficult to get hold of cigarettes?

Hasan: No.

Adan: Never.

Salman: Nah, it's very easy. It's because back home [Bangladesh], the whole place is overcome by it.

Adan: Yea back home, it's just everywhere when we went to visit. I could get em easily.

(Bangladeshi male group: pg. 6/ lines 165-169)

Lisa: I've not got cigarettes from those guys who sell em on the street.

All: Yea

Melanie: We definitely bought them when we was on holiday, cos they were like one euro for twenty. Not done that in this country though.

(White British female group: pg. 22/ lines 515-518)

Next, seeking monetary assistance involved asking parents for money, and seeking alternative means to access included asking friends or strangers on the streets for spare cigarettes. Finally, with regards to smoking roll-ups, the White British male group described how they smoked roll-ups as they lasted longer:

Liam: That's why I smoke roll ups, not cigarettes. If I bought like a box of 20 it would last me about half an hour but if I like bought a box of tobacco, it would last me about a few days.

Robert: Tobacco always lasts you for longer.

(White British male group: pg. 10/ lines 280-282)

Overall through attempts at reclaiming freedom to smoke it is apparent how participants wish to remain in the smoking world, which indicates the attachment they have

with the smoking world. Encountering challenges to their smoking behaviour requires participants to reflect on the reality of their smoking world and to negotiate it accordingly.

3.4.1.4. Relinquishing smoking freedom

All of the focus groups demonstrated acceptance of relinquishing their freedom to smoke, through the acceptance of legal and socio-cultural barriers.

3.4.1.4.1. Acceptance of legal barriers

All of the female groups and the Bangladeshi male group illustrated acceptance of legal barriers to smoking, which consisted of psychological acceptance. This was illustrated by having positive attitudes towards legal barriers to accessing cigarettes and location for smoking. For example, positive attitudes towards legal barriers to access, included having agreement and believing in the effectiveness of using of graphic images on cigarette boxes and the tobacco purchase age law:

> "The thing is about me, it does make me think about the side effects, the whole time... After I'm looking I'm thinking yea I've got consequences I've got to take. So if I'm smoking a cigarette I'm smoking a death stick...Yea, I see the diseases and I could end up with these dirty effects and I could mess it up for the rest of my life."
>
> (Melanie, White British female group: pg. 10/ lines 219-226

Also with regards to acceptance of legal barriers to location, participants from the Bangladeshi female and White British female groups expressed positive attitudes towards the smokefree laws in public places,. This was due to cessation and environmental purposes. Participants from the Bangladeshi male and White British female groups demonstrated

positive attitudes towards introducing future legal barriers to their smoking, primarily to aid with future cessation attempts:

> "I think erm in regards to that I erm obviously it's going to make it a lot more difficult to smoke but it's also a good thing....Because I'm thinking that there's a lot more people that have actually cut down a helluva lot when they go out especially cos you know when you have the alcohol you need the cigarette. It kind of goes together. Erm whereas now they're just like, they don't even think about it because we know we can't smoke in a club anymore so there's no point in wasting that extra £5 and buying a pack of 20 cigarettes. We might as well save that £5 so erm that's one of the good things." (Sanchita, Bangladeshi female group: pg. 96/ lines 2156-2164)

> "With smoking yea it should be banned publicly because a lot of people walk past but on roads smoking...I used to pass a big road yea and some guy was smoking into me. I was like passive smoking and let's say one day I stopped smoking yea, I don't wanna have that." (Salman, Bangladeshi male group: pg. 26/ lines 643-647)

3.4.1.4.2. Acceptance of socio-cultural barriers

Both of the Somali groups and the Bangladeshi female group demonstrated psychological acceptance of socio-cultural barriers to their smoking freedom. This was firstly demonstrated behaviourally by the Somali female group, through undertaking attempts at cessation due to parental encouragement for cessation, and concealing smoking behaviour from others due to parental request:

> I: It seems that affected you because it was enough to make you want to try to stop.
>
> Amina: Yea he [father] wanted me to stop the cigarettes.
>
> (Somali female group: pg. 55/ lines 1083-1084)

> "...and so when he's [uncle] in the house yea I try to like hide it. They can smell it from the house, so I have to spray it or I have to smoke quickly like before they come." (Deeqa, Somali female group: pg. 21/ lines 404-406)

Next, it was indicated by both of the Somali and Bangladeshi female groups, through forming or strengthening intentions to quit due to others' encouragement for cessation and also by having empathic beliefs about others' encouragement for cessation and being in agreement with others' rejection of their smoking behaviour:

> "And she [teacher] goes 'that's very bad you shouldn't have started again' and I was like 'hopefully I will stop again'." (Deeqa, Somali female group: pg. 49/ lines 954-957)

> "And you know they just, it's not that they [peers] don't understand cos totally, if I didn't smoke and my friends smoke I'd probably do the same thing as well, like 'you know you shouldn't do it' de de de...there's a certain extent where you will say it if you care about the person and stuff and yea that's it." (Priya, Bangladeshi female group: pg. 19/ lines 456-463)

Overall it is apparent that participants are also tolerant of the external challenges which are made to their smoking world. As with reclaiming freedom to smoke, this process requires reflection and negotiation of their smoking realities which for some participants even results in rejection of the smoking world and an attempt to regain entry into the non-smoking world.

3.4.2. Control

The main theme of control was associated with control over smoking behaviour and consisted of loss of control and regaining control, which will be discussed in turn.

3.4.2.1. Loss of control

All of the focus groups described loss of control over their smoking behaviour which was demonstrated through addiction to smoking. This involved getting addicted and being addicted.

3.4.2.1.1. Getting addicted

Getting addicted involved the process leading to addiction, prompt to realisation and response to addiction and was discussed by all of the groups. Firstly, with regards to process leading to addiction, this included physiological, psychological and social factors leading to addiction. Physiological factors involved desire to prolong physiological pleasure and developing tolerance to physiological effects, which were described by the Bangladeshi female and Somali female groups:

> "...it made me feel dizzy and stuff and I just liked that feeling. But after a while it went but that's when I started getting addicted to it." (Bharati, Bangladeshi female group: pg. 5/ lines 127-129)

> "...and then eventually you start getting used to it, it starts becoming something, it's not as disgusting, it's like food and you always eat food. After a while you think it's ok and then that's certainly how it is with a cigarette." (Ayan, Somali female group: pg. 7-8/ lines 144-146)

Psychological factors firstly comprised of behavioural factors, which included mastery over the smoking technique and increased consumption of cigarettes that led to addiction. These were mentioned by both Somali groups and the Bangladeshi female group:

> "...and I just got kinda in the habit of smoking so I thought I struggled at first to smoke but then after I got used to it..." (Taban, Somali male group: pg. 2/ lines 67-69)

> "...I just constantly bought cigarettes and smoked more and then now it's just become a habit..." (Priya, Bangladeshi female group: pg. 4/ lines 106-107)

Psychological factors also included having a belief in control over smoking and using smoking as an emotional coping strategy, which was stated by the Somali female, Bangladeshi female and White British male groups.

> "But I didn't listen, I felt I could control it but then when it got to like a month or so then I realised like I need it." (Deeqa, Somali female group: pg. 4/ lines 70-71)

> "...yea like every time I was proper stressed you would have a cigarette and that's how you get hooked, that's what did I anyway." (Liam, White British male group: pg. 3/ lines 81-82)

Finally, social factors were mentioned by the Somali female group and involved being around other smokers.

> "I was with cousins and they used to smoke around me and everything and then I just got addicted to it." (Hawiiya, Somali female group: pg. 6/ lines 111-112)

Next, prompt to realisation of addiction was mentioned by all the groups and involved the realisation of needing to smoke and not being able to quit.

"You realise when you need it and when you see that you just can't go without it..."

(Adan, Bangladeshi male group: pg. 21/ line 530)

Sean: I always kept saying oh you know that I could stop whenever I wanted.

Robert: Yea that's what I was like, same with me, I can stop whenever I want.

I: Ok.

Robert: It was a couple of months before I realised I can't, I'm actually addicted.

(White British male group: pg. 21/ lines 623-626)

Finally, response to addiction was discussed by all the groups except the Somali male and White British female groups. This included experiencing feelings of regret, shock and dismay at the realisation of being addicted:

"Oh God I regretted it when I knew I was addicted. That was when I was about 15."

(Sanchita, Bangladeshi female group: pg. 90/ lines 2025-2027)

Ayan: I thought about, the fact that, when I realised I was a bit like, first I was a bit shocked. I wanted to stop and then when I realised I couldn't stop it was bit of a shock cos I didn't ever think I would ever be addicted to cigarettes and smoking. It was just a bit like 'oh my god what have I put myself into? What a hole.'

Nadifa: 'What have I started?'

Ayan: Yea.

(Somali female group: pg. 55/lines 1092-1097)

"...and that's when you think, 'oh shit'." (Adan, Bangladeshi male group: pg. 21/ line 531)

3.4.2.1.2. Being addicted

Being addicted consisted of physiological signs of addiction and behavioural signs of addiction, which were demonstrated by all of the groups. Firstly, physiological signs of addiction were mentioned by all the groups and consisted of a 'need' to smoke, greater tolerance of cigarette smoke, experiencing a cycle of withdrawal and loss of appetite. With regards to need to smoke, this was described by all of the groups in a physiological sense of needing to smoke.

"...if you need a cigarette and you've not got it with you it's like there's a sign in your head, like there's an alarm telling you that you have to have a cigarette now.... It's like you know when your alarm rings when you're waking up, it's the same thing with cigarettes. An alarm telling you, you have to smoke, like right inside you head, like proper there, you can feel it." (Deeqa, Somali female group: pg. 34/ lines 650-658)

Greater tolerance of cigarette smoke was mentioned by the White British female and Somali female group:

Tina: I said now you don't even care if people smoke around you when you did before.

Claire: Because you smoke yourself.

Tina: Yea.

(White British female group: pg. 5/ lines 105-107)

Next, experiencing a cycle of withdrawal was stated by all of the groups. This included experiencing i) cravings to smoke (which were described as feelings of urgently wanting, needing and thinking about cigarettes, with some participants describing them as tangible sensations in their mind), ii) deviance from normal physiological state (which included experiencing symptoms of stress, anxiety and irritability when having not smoked for a period) iii) urgency to relieve craving when having not smoked for a period followed by iv) restored equilibrium of physiological state when the craving was appeased (which involved experiencing feelings of calm and pleasure when cravings were appeased):

Tina: And like, like before yea, me and her [Claire] was down the road innit and she was proper stressed yea and I had to chills [calm] her cos she was proper stressed. She was like 'spark up now'. We was walking along some park in the alley and she was like 'spark it'. She literally grabbed me up by my throat, that's how bad it was for her. That's how badly she needed that cigarette.

Claire: Innit.

Tina: Yea.

Claire: I was proper stressed.

(White British female group: pg. 12/ lines 261-268)

Abdi: It calms you down. After you have it, it chills you right out – it's a good feeling to be calm.

I: Right, ok.

Taban: Basically yea say you was hungry for days yeah and then you had nothing to eat and then you saw this juicy piece of chicken and you just took a bite out of it. How nice would that feel?

I: Hmm.

Taban: That would feel nice innit?

I: Yeah.

Taban: So when you're really craving like and you take a cigarette just feels relaxing. It feels nice.

(Somali male group: pg. 15/ lines 373-383)

Finally, loss of appetite was discussed, which involved smoking appeasing hunger and prioritising the purchase of cigarettes over food.

David: Most of the time I spend money on fags not food.

I: Really?

Robert: Hmm.

All: Yea.

David: It's like if I had £5 on me, and I was hungry I would want fags more than food, I'd rather have cigarettes.

(White British male group: pg. 10/ lines 283-288)

Next, behavioural signs of addiction were demonstrated by all the groups and consisted of having triggers and routines to their smoking and increased and regular cigarette consumption. Firstly, with regards to triggers to smoking, a variety of triggers were described throughout the day, which included when waking up, before going to sleep, after meals, with specific beverages, during break times, with other substances, during stressful or social situations, observation of others' and talk of smoking. Preferences were also stated for specific triggers, including the first cigarette in the morning, after meals and with alcohol:

David: Yea the best one is after you eat definitely or when you first wake up in the morning.

Others: yea.

David: Yea the morning cigarette, that's the best one.

Robert: You have to.

(White British male group: pg. 7/ lines 207-210)

Secondly, routines were also described for the smoking behaviour, which provided a structure to the daily smoking behaviour.

"And also like you know when you get, you know you get addicted to cigarettes, it's sometimes I think it's because it becomes a timetable where you know when you're gonna have the cigarette, do you know what I mean? Like basically with me I have to have a morning cigarette...and then after lunch I'll have to have one...and in college cos there's a lot of breaks and stuff now I know which break I'm gonna have a cigarette..." (Priya, Bangladeshi female group: pg. 16/ lines 368-380)

Finally, increased and regular cigarette consumption was discussed by all of the groups. This involved having triggers which increased normal cigarette use, such as stressful situations, alcohol use and socialising with peers.

Zahir: When I take alcohol that's the best.

Adan: Me as well, 10 packs will go, just like that.

Zahir: Just like that.

Salman: To keep the buzz going they will have to smoke more cigarettes.

(Bangladeshi male group: pg. 30-31/ lines 763-766)

Overall it can be seen that with the loss of control, volition to remain in the smoking world is somewhat denied to participants and instead there is a more forced residency. It is

apparent how this reality of the smoking world was often revelatory to participants and not originally anticipated.

3.4.2.2. Regaining control

All of the focus groups illustrated attempting to regain loss of control over their smoking behaviour, through either attempts at cessation or abstinence for Ramadan. There were facilitators to their attempts at regaining control and also barriers, which will be discussed in turn.

3.4.2.2.1. Facilitators to regaining control

All of the groups expressed facilitators to regaining control, which consisted of i) drive for cessation ii) intentions for cessation iii) self-efficacy for cessation iv) method for cessation and v) method for abstinence.

i) Drive for cessation involved drive for past quit attempts, current quit attempts and quit attempts envisaged for the future. Firstly, drive for past quit attempts consisted of internal and external drive. External drives comprised of religious drives in the form of quitting for Ramadan, which was stated by all the groups except the White British groups, parental request for cessation and prevention of second-hand smoke to other family members, which was mentioned by the Bangladeshi female and Somali female groups. It is to be noted that stopping smoking for Ramadan was mainly based on intent for abstinence rather than complete cessation. Internal drives to smoke were stated by the Bangladeshi female and Somali female groups and consisted of health reasons and desire not to be dependent on cigarettes:

"I wanted to stop because my dad found out; he wasn't happy and told me to stop."

(Amina, Somali female group: pg. 54/ line 1067)

> "Yea I try and stop smoking for Ramadan, it's for religious reasons so I think it's important you try and stop." (Roble, Somali male group: pg. 26/ lines 663-664)

> "I dunno just, I just wanted to stop, like just for myself, for my health and stuff and I dunno, not to be dependent on it and stuff." (Bharati, Bangladeshi female group: pg. 47/lines 1100-1101)

Next, drives for current quit attempts again consisted of internal and external drives. External drives were mentioned by the Somali female and Bangladeshi female group and comprised of religious reasons, peer request for cessation and the smokefree public places law:

> Ayan: Yea of course that's [religion] another reason, after my parents, well it should be before my parents, but after my parents that is the biggest thing, that in terms of like having a cigarette you always still remember oh 'I shouldn't smoke'.
> Nadifa: When you're smoking and stuff you think 'ah shit it's haram' [forbidden].
> Ayan: I'm doing something that's not good you know and I need to stop for that reason as well. In a way when you think about stopping that also motivates you to stop, cos you're like look it's...
> Nadifa: It's haram I shouldn't be doing it.
> (Somali female group: pg. 29/ lines 568-575)

Internal drives were expressed by the White British male, Somali female and Bangladeshi female groups and consisted of health reasons (e.g. minimising risk of physical health problems, improving fitness and having concern over the content of cigarettes), impact on physical appearance and hygiene (e.g. concerns about weight, ageing and not liking to smell

of cigarettes), financial reasons, reluctance to be a negative role model for young people (e.g. younger siblings) and negative psychological response towards smoking (e.g. lack of emotional fulfilment from smoking and negative attitudes towards smoking).

Sean: It's not about the money really, it's your health.

David: It's you live longer, your health.

Sean: Totally.

David: It's like my fitness at the moment is so shit, so bad.

(White British male group: pg. 20/ lines 573-576)

Ayan: But I want to stop smoking for the better...and when I'm seeing young people smoking, like younger than me, 7, 8, 9 and 10 years and I do see it. When I see people like that smoking I think you know they're probably smoking because of us lot, because they see people older than them that smoke.

Nadifa: Another reason why I want to stop is cos I've got a little sister basically. She sees that everyone in my house, basically all my sisters and my brother we all smoke, she sees us smoking, she sees us smoking and then I feel bad cos she tries to steal our cigarettes sometimes.

I: Does she?

Nadifa: Yea she's young. She's only in year 8, 12/13 years and she tries to steal our cigarettes.

I: Right ok.

Nadifa: Yea but then it's like I don't want her to start smoking, obviously it's my younger sister so I don't want her to.

(Somali female group: pg. 57/ lines 1121-1133)

Finally, drive for future quit attempts were mentioned by the all the groups except the White British female group, which included quitting for New Years' resolutions or for specific future life milestones and ages. Future life milestones firstly included getting married, which was discussed by the Somali female and Bangladeshi female groups:

> "I would never wanna put shame on my husband's family by smoking, it would be shameful if you found out your daughter in law is smoking..." (Priya, Bangladeshi female group: pg. 67/ lines 1536-1537)

They also included having children, which was discussed by all of the groups except the White British female and involved issues around increased responsibility, fertility, dangers of direct and second-hand smoke to babies and children, increased chance of own children smoking and having a head-start to quitting when pregnant. For example:

> "I reckon my kids will motivate me to stop... Nah seriously, if you got kids bruv you don't wanna be smoking around them." (Dalmar, Somali male group: pg. 31-32/ lines 790-792)

Finally, they included quitting both before and after university and when settled in future careers, such as being a businessman and social worker:

> "No actually. I don't wanna smoke when I'm older as I want to be a businessman." (Salman, Bangladeshi male group: pg. 28/ line 700)

With regards to age milestones, these were discussed by the White British male, Somali female and Bangladeshi female groups and included just before turning 18, due to not wanting to be a bad role model to younger people and in the 20s and 30s, due to increased wisdom, being more settled in life and not being a teenager anymore. For example:

Jack: When you're in your 20s.

Liam: Yea that's what I said, 20, 21.

I: Why 20, 21?

Liam: Cos that's the time when you're settling, you've got a proper job and stuff and you're just kind of set for life.

(White British male group: pg. 19/ lines 553-557)

ii) Intentions for cessation were discussed by all of the groups by stating that they wanted to quit either in the present or in the future:

Claire: I'm trying to stop. I don't really want to smoke.

Tina: Me as well, I want to stop.

(White British female group: pg. 16/ lines 376-377)

Abdi: I'll hopefully quit one day.

I: Yea.

Erasto: Inshallah. [God willing]

Taban: One day.

(Somali male group: pg. 33/lines 823-826)

iii) Self-efficacy for cessation was relayed by both of the Somali groups and the Bangladeshi female group. This was due to witnessing others' quit attempts, experience of previous quit attempt and belief in ease of cessation:

"...and I was thinking to myself, 'hold on if my uncle can do it and he's gone through so much and he's been smoking for so long, why can't I?' So I think it's a piece of cake for me..." (Priya, Bangladeshi female group: pg. 65/ lines 1493-1495)

> "But honestly if I wanted to stop today I could stop. I could throw the cigarettes away and stop at once." (Abdi, Somali male group: pg. 6/ lines 170-171)

iv) Method for cessation was discussed by all of the groups. This included methods they had used for previous cessation attempts and methods they planned to use for future cessation attempts. Methods used for previous quit attempts were discussed by all of the groups and consisted of presence of support from others, the approach employed to quitting, use of behavioural coping strategies and the use of aids to quit. Firstly, presence of support from others included not getting support and quitting alone, which was stated by the White British male and Bangladeshi female group. It also involved getting support from family members and professional NHS services, which was mentioned by participants from the Somali female and Bangladeshi female group:

> Anjali: That's what me and my counsellor spoke a lot about.
>
> I: You were seeing a counsellor?
>
> Anjali: Yea, for a year. That's the type of thing we used to talk about to try and get me to stop smoking. He did refer me to the nurse as well to get smoking support from her.
>
> (Bangladeshi female group: pg. 87-88/ lines 1981-1984)

Next, approach to quitting included the 'cold turkey' approach, which was employed by participants from the White British male, Somali male and Bangladeshi female group and also the cut down approach, which was discussed by the White British male and Bangladeshi female group:

> Robert: Whenever I've tried to stop smoking yea I don't just stop straightaway, I try to cut down and then stop. So like say I have 10 a day I'll go down to like 5 a day and then I'll go down to 2, then 1 and then I'll try to stop. I would just like say 'right that's it, last fag, not gonna smoke again.'
>
> I: Ok how about the rest of you?
>
> David: Same way.
>
> (White British male group: pg. 16/ lines 461-464)

Behavioural coping strategies were mentioned by both of the Somali groups and the Bangladeshi female group, which consisted of avoidant strategies, through the avoidance of smokers and cigarettes, and distraction techniques:

> Deeqa: Yea and I tried to stop it and I went on holiday cos here yea everyone smokes around you. So I went on holiday.
>
> I: What was that like?
>
> Deeqa: It was alright. No one smokes there because everyone is like dead religious. Most of the people are religious there because it's like a Muslim country so you won't find no women or girls or people like smoking in the house...
>
> (Somali female group: pg. 52/ lines 1023-1028)

Finally, the use of aids for quitting included pharmacological aids, like Nicotine Replacement Therapy (NRT) products and non-pharmacological aids, such as regular sweets and gum, which were mentioned by all of the groups:

> Melanie: Yea, I tried the inhaler...She's tried the patches. [to Claire]
>
> Vicky: I've tried the gum...
>
> (White British female group: pg. 14 /lines 319-326)

Next, methods to be used for future quit attempts were discussed by all of the groups and involved presence of support from others, the approach to quitting, use of behavioural coping strategies, use of aids to quitting, replacing smoking with shisha use and the importance of willpower. Firstly, with regards to support from others, the White British female group expressed how they would like to quit in a stop smoking group as opposed to seeing a health professional:

Claire: Nah I wouldn't like to see a doctor or someone like that.

All: No.

I: So what would you prefer?

Claire: I'd like something like this.

Lisa: Exactly, where we all know each other and can all talk together.

(White British female group: pg. 22-23/ lines 530-534)

Approaches to quitting involved the cut-down-to-quit approach and the use of hypnosis, which was mentioned by the Bangladeshi female group:

"I would like to try hypnosis. I think that'd work as you wouldn't want the cigarettes." (Dipika, Bangladeshi female group: pg. 81/ line 1842)

Behavioural coping strategies were described by all the groups, except the White British female group and included the use of avoidant strategies (e.g. avoiding access to cigarettes and other smokers) and distraction techniques (e.g. keeping occupied with normal daily routines):

"If you're by your friends then change your friends if they are not good for you."

(Ayan, Somali female group: pg. 61/ line 1207)

> "You have to keep yourself busy and not like think about it [smoking] you know."
> (Salman, Bangladeshi male group: pg. 20/ line 504)

Aids to quitting were mentioned by the Bangladeshi male, White British female and Somali female groups and included the use of non-pharmacological aids, such as normal gum and shisha, and pharmacological aids comprising of Nicotine Replacement Therapy products:

> "I think, as I really really want to smoke I think I'm so used to taking something in and just getting it out, so I think I'll probably just do shisha for a while instead."
> (Mala, Bangladeshi female group: pg. 83/ lines 1886-1887)

Finally, all of the groups, except the White British female and Somali male groups, expressed the importance and sometimes exclusive importance of willpower for future quit attempts.

> Ayan: You just have got to be mentally like.
> Amina: You have to put your mind on it.
> Ayan: Yea you have to put your mind on it.
> Amina: It's not that easy but it's mental.
> Ayan: I think stopping smoking is not a thing where someone else can say to you 'oh stop smoking', that's not gonna make you stop smoking, you mentally you have to do it yourself, it's something no one else or nothing else can make it happen.
> (Somali female group: pg. 61/ lines 1214-1220)

v) Method for abstinence referred to the methods used by the Muslim participants to abstain from smoking for Ramadan. These were described by both the Somali groups and the

Bangladeshi female group and involved psychological techniques. Psychological techniques involved the use of positive cognitions, praying and willpower and also the use of behavioural techniques including topping up with cigarettes before fasting:

> "...I was like 'oh my god I could just easily just spark up' and then I felt sooo bad you know I thought 'look I've been through half the day anyway I might as well just continue with it'." (Priya, Bangladeshi female group: pg. 46/ lines 1066-1068)

> "You know like at the end of the day I'm determined innit. I've got that drive. I'm practising and I'm praying and you know I'm just in the zone." (Ghedi, Somali male group: pg. 27/ lines 675-676)

> "I try and make sure I have like a million cigarettes before." (Nadifa, Somali female group: pg. 30/ lines 586-588)

3.4.2.2.2. Barriers to regaining control

All of the groups expressed barriers to regaining control over their smoking behaviour. This consisted of i) barriers to cessation and also ii) barriers to abstinence for the Muslim participants when abstaining from smoking for Ramadan.

i) Barriers to cessation involved barriers to past cessation attempts, current cessation attempts and future cessation attempts. Barriers to past cessation attempts comprised of relapse triggers, which were an immediate catalyst for relapse and quit obstacles, which presented challenges to the quit experience but were not responsible for the moment of relapse. Relapse triggers for past quit attempts were expressed by all the groups. These firstly included temptation by other smokers, which was mentioned by all of the female groups and the Somali male group. Temptation by other smokers consisted of a passive and active

temptation. Passive temptation resulted from observing others smoking (e.g. strangers on the street, peers and family members), which the Somali male and Bangladeshi female group felt was heightened in social situations:

> "...I don't smoke for 2 weeks and then within a matter of 2 weeks I'll feel like I ain't never smoked before and then I'll get out on a Friday night and I'll just buy some fags and that's it. So it tempts me going out with people man." (Abdi, Somali male group: pg. 5/ lines 128-130)

Active temptation centred on peers actively jeopardising quit attempts (e.g. through questioning the quit attempt, excluding participant from the peer group and deliberately tempting participants with cigarettes as a result of jealousy):

> Claire: Right, it's hard cos all your friends smoke you know and they're like 'why are you going and stopping?'
>
> I: Yea?
>
> Claire: All our friends are sitting there, like all of your friends are sitting there smoking and you're not and you just feel so odd and everyone else looks at you like 'why are you here if you don't wanna smoke?'
>
> All: Yea, yea.
>
> (White British female group: pg. 13/ lines 297-303)

Relapse triggers also included coping with stressful situations, which was mentioned by the Somali male group, Bangladeshi female and White British female groups:

> "I've done it [quit] for 2 months. Somehow my brother had a fight and I started again. My brother had a fight and then I started again...He had a fight with me, pissed me off

and then I started again. It calms me down." (Roble, Somali male group: pg. 26/ lines 664-666)

They also included alcohol consumption, which was expressed by the Bangladeshi male group, and involved gaining pleasure from combining cigarettes and alcohol, which thwarted New Year's smoking cessation resolutions:

Zahir: New Years Day you end up smoking!

Adan: New Years Day exactly!

Zahir: You get a buzz and everything else innit!

Adan: Yea!... Especially when you're titchy [drunk].

Zahir: Exactly like.

I: You get a buzz when you smoke at New Years because you're drinking too?

Adan: Yea.

Zahir: Yea you wanna keep the buzz going and cigarettes will help keep the buzz going.

Adan: Yea.

(Bangladeshi male group: pg. 30/ lines 748-760)

Relapse triggers also involved the experience of withdrawal symptoms (e.g. feeling on edge, irritable, depressed, stressed, unable to concentrate and experiencing weight gain), which were discussed by all the groups, except the White British female group:

"Now when I try go and stop, it's just like for one day because the next day essentially I go crazy man and like I just need one." (Adan, Bangladeshi male group: pg. 4/ lines 109-110)

Finally, personality factors were mentioned by Sanchita from the Bangladeshi female group, which consisted of having a lack of willpower and an addictive personality:

> "I have a very addictive personality, like if I try something once and I really like it I'll continue with it....I have that problem you see." (Sanchita, Bangladeshi female group: pg. 72/ lines 1648-1651)

Next, quit obstacles were described by all the groups and included negative experience of quitting aids, difficulties breaking old smoking routines and temptation by media smoking influences. Firstly, with regards to negative experience of quitting aids, this was mentioned by all of the groups and included jaw ache from the chewing of regular gum and experiencing negative physical effects when using Nicotine Replacement Therapy products resulting in beliefs over their ineffectiveness:

> Hasan: I tried the gum, the chewing gum.
>
> Zahir: It made me feel sick.
>
> Hasan: The patches.
>
> Adan: That made me feel sick.
>
> Hasan: And you know that little nicorette thing.
>
> I: Yea, the small white inhalator thing?
>
> Hasan: Yea, it still didn't work, so I thought f**k it, not using that.
>
> (Bangladeshi male group: pg. 19-20/ lines 493-499)

Difficulties in breaking old smoking routines were mentioned by the Somali male group:

> "Thing is yeah you're like so used to buying cigarettes from the shop, buying fags in the morning or whenever you run out. So when you quit yeah you say 'yeah I've quit' and I guess after a while you don't even notice it but you see yourself going into the

shop and buying yourself cigarettes cos you're so used to it like. It's like a routine, you don't mean for it to happen." (Taban, Somali male group: pg. 6/ lines 150-154)

Finally, the Somali female group mentioned temptation to smoke resulting from media smoking influences:

"The only times I would think about it was when I would see it on the TV and I would change the channel quick." (Deeqa, Somali female group: pg. 52/ lines 1033-1034)

Next, barriers to current cessation attempts were discussed by all the groups except the White British male group, which included lack of drive for cessation, lack of self-efficacy and lack of readiness for cessation. With regards to lack of drive for current cessation attempts, this was mentioned by all the female groups and the Bangladeshi male group. Firstly, this lack of drive resulted from lack of concern over effects of smoking, which stemmed from incorrect health beliefs regarding the negative effects of smoking and a belief in negative effects on appearance occurring longer-term:

"Her [peer's] grandma would go up the stairs, then she would stop in the stairs and she'd start smoking. She'd spark up a cigarette and I'd be so scared. I'd think 'what is she doing, she'll die' but my friend said to me when she went to the hospital they told her 'smoke, it's good for you'...I thought back to myself 'oh if it's good for you then why am I gonna try stopping smoking? I'm gonna carry on if it's good for me'." (Nadifa, Somali female group: pg. 59/ lines 1167-1173)

Lisa: Yea, I don't really worry about the wrinkle effects now.

Vicky: Yea that's more in the future.

(White British female group: pg. 11/ lines 237-238)

It also resulted from having positive attitudes towards smoking and from using smoking as a psychological coping mechanism to deal with anxiety and stress:

> "...I don't think there's anything wrong with it ..." (Nadifa, Somali female group: pg. 28/ lines 553-554)

> "...I know if I wanted to stop smoking I will try and stop smoking but at the moment I'm kind of stressed out and stuff. Just like at the end of the day I come home from a long day, my college finishes at 5, I smoke throughout college anyway with my friends and stuff. I go home and I watch TV and I just sit there smoking. And it's just a way to unwind at the end of the day...and I have trouble sleeping as well. If I smoke enough I will eventually drop off to sleep." (Anjali, Bangladeshi female group: pg. 55/ lines 1267-1274)

Lack of drive for cessation also involved deriving emotional pleasure from smoking, with participants saying they still liked smoking and describing it as fun and enjoyable.

> Adan: At the moment it's just about making the future.
>
> Salman: Yeah having fun.
>
> (Bangladeshi male group: pg. 29/ lines 733-734)

Next, lack of self-efficacy regarding current quit attempts was expressed by the Somali male and Somali female groups. For some participants this lack of self-efficacy stemmed from concerns regarding the length of smoking behaviour and the influence of other smokers:

> "As you get older you want to stop innit so but now it's hard for me to stop like cos I've been smoking for about 5 years." (Dalmar, Somali male group: pg. 8/ lines 205-206)

> "Even now I want to stop but I don't know if I can. I know non-smokers and people that smoke but the majority of them smoke so I dunno." (Deeqa, Somali female group: pg. 52/ lines 1038-1039)

Finally, lack of readiness for current cessation was stated by both the Somali groups and the Bangladeshi female group and included not having the feelings to stop and not being mentally prepared for quitting:

> "And at the time the feeling that you wanna stop comes then I'll stop but right now I don't have that feeling." (Mala, Bangladeshi female group: pg. 67/ lines 1529-1530

> "Yea, if you set your mind to it, you can do it but I just haven't set my mind to it yet." (Deeqa, Somali female group: pg. 65/ line 1293)

Barriers to future cessation attempts were expressed by all of the groups and included lack of intentions to quit, lack of self-efficacy to quit and cultural barriers. Firstly, lack of intentions regarding future cessation attempts were demonstrated by the White British female group. Lisa discussed how she could still envisage herself smoking in the future, which stemmed from a belief of addicted smokers not getting bored of smoking:

> "Yea but you wouldn't get bored of it when you're addicted... I can see myself smoking like 40 a day [laughs]." (Lisa, White British female group: pg. 11,16 / lines 378, 243)

Next, lack of self-efficacy was expressed by the both the Bangladeshi groups, the White British male group and the Somali female group. This usually involved having a desire to quit but lack of self-efficacy and for some participants this lack of self-efficacy stemmed from the length of smoking behaviour and the influence of other smokers:

> Hasan: But we're always gonna be around someone else whose smoking anyway. So it's not going to work, you're gonna end up twosing with them, sharing a cigarette at the end of the day like.
>
> I: Ok so you think being around other smokers will have an effect on you when you try to stop?
>
> Hasan: Yea.
>
> Adan: Yes that's why I think it's harder to stop.
>
> (Bangladeshi male group: pg. 26/ lines 691-697)

Finally, with regards to cultural barriers, the Somali male group discussed how cultural differences between Somali and the White British population resulted in Somalis being less concerned about their health, which then impacted on efforts undertaken to quit successfully:

> Taban: Like I said yeah the white population's going down [smoking prevalence] and the Somalis and the Bengalis are going up.
>
> Ghedi: That's cos the white people have sense.
>
> Taban: Cos white people actually take the time to buy the stuff.
>
> Ghedi: They've got more money to buy it.
>
> Taban: And us we never try it and we think that it don't work. We think 'ah it don't work' but we never tried it.
>
> I: So you think it's a money thing then or that it doesn't work or it does work?

Abdi: I think they're scared of dying man that's what I think.

Dalmar: Yea they're scared of dying.

Abdi: You can tell the white person that you're gonna die.

Dalmar: He will be like 'waahh ahhh.'

Abdi: He will be crying. But the Somalis don't care really.

Taban: We're all gonna die one day innit.

Erasto: They get really stressed.

Taban: If we're gonna die with a fag in our hand, we're gonna die with a fag in our hand.

(Somali male group: pg. 29-30/ lines 726-758)

ii) Barriers to abstinence were expressed by both of the Somali groups and both of the Bangladeshi groups in reference to abstaining from smoking during Ramadan. These barriers firstly included triggers to relapse, which included cravings to smoke:

Xaali: "...we were both fasting innit, and her mum [Ayan's mother] comes in and she's like 'are you girls fasting?' And we were like 'yea yea yea' and then we forgot about cigarettes innit but then as soon as her mum came into the room and said 'are you girls fasting', I was like 'yea' but then when she left I was like 'ahh I want to smoke now' and then I said to her [Ayan] 'I want a cigarette' and she was like 'me too man' and then I don't know what happened there man, we just started suddenly thinking about it.

Ayan: We started craving for it basically.

Xaali: Yea we got a bare [big] craving for it and went downstairs and we was like 'let's have a cigarette'.

(Somali female group: pg. 31/ lines 610-617)

They also included obstacles encountered, which involved temptation by other smokers and difficulties in breaking daily smoking routines:

> "....I was absolutely dying and then I was walking down * road and I saw so many people smoking and I had a full box in my bag and wanted to smoke." (Priya, Bangladeshi female group: pg. 46/ lines 1064-1066)

Salman from the Bangladeshi male group also discussed barriers in transferring abstinence for Ramadan into longer-term cessation, by stating the use of smoking as a reward:

> "But I carry on smoking after Ramadan innit cos I gotta release it with something innit. I've got through it so I need a release." (Salman, Bangladeshi male group: pg. 12/ lines 307-308)

Overall it can be seen how the reality of the smoking world can lose appeal, resulting in attempts to leave the smoking world and regain entry into the non-smoking world. The complex nature of this process is revealed and despite unsuccessful attempts to achieve this or current desire to remain in the smoking world, there still generally remains an expectation to return to the non-smoking world at some point in the future.

3.4.3. Quality of life

The main theme of quality of life consisted of enhanced quality of life and deprived quality of life as a result of smoking, which will now be discussed in turn.

3.4.3.1. Enhanced quality of life

All of the focus groups described how smoking enhanced their quality of life. This was indicated through drive to smoke, lack of drive for cessation and positive effects of smoking. As lack of drive for cessation was discussed earlier in the control theme it will not be discussed here.

3.4.3.1.1. Drive to smoke

All of the groups discussed their drive to smoke. This involved gaining emotional fulfilment from smoking, using smoking as a coping mechanism and for social functioning.

Firstly, gaining emotional fulfilment from smoking was mentioned by all the groups and involved liking the act of smoking and associating it with pleasure and as a reward in life:

> "I like the smell of smoking...and I like the taste of it. If I didn't like the smell then I wouldn't smoke." (Bharati, Bangladeshi female group: pg. 101/ lines 2279-2281)

Next, using smoking as a coping mechanism was discussed by all the groups and involved smoking helping in coping with either emotional stress (e.g. dealing with feelings of anger, upset and general stress) and/or boredom. The Bangladeshi female group acknowledged that smoking did not completely alleviate the root cause of the stress but provided an outlet for it:

> "And then it just, I don't know, I think it helped a lot with getting rid of stress, obviously it didn't get rid of the problem or whatever but you know it helped a lot, it was like a reaching a release and stuff." (Priya, Bangladeshi female group: pg. 3/ lines 98-100)

The Somali groups discussed the comforting properties of smoking in dealing with these situations, with some participants describing cigarettes as a 'best friend':

Nadifa: I think cigarettes is my best friend...Really I find it's my best friend because yea it's always there for you.

Ayan: Always there for you.

Nadifa: Yea, when you need it, it's there to comfort you.

Ayan: Especially when you don't have anyone else around you.

(Somali female group: pg. 37-38/ lines 733-739)

Sanchita from the Bangladeshi female group discussed how smoking aided her stress due to the effect of nicotine whereas the White British male group believed that smoking helping with stressful situations was more of a psychological than physical phenomenon:

Robert: If you have an argument with someone, if you feel really angry, just have a cigarette and it calms you down.

Liam: The thing with cigarettes though it doesn't actually calm you down, but you think because it's gonna calm you down. It's more a state of mind than physical. It's not like an actual antidepressant I don't think.

Robert: It's not, it's not, it's just like the feeling ain't it?

Liam: Yea, it makes you feel like you've calmed down but physically it hasn't.

(White British male group: pg. 7-8/ lines 212-218)

With regards to coping with boredom, the Bangladeshi male group spoke about how smoking helped to pass the time:

Hasan: It's a pastime as well in life, when you're bored like this.

Others: Yeah.

I: Ok.

Hasan: Yeah.

Zahir: Pass the time as well. Like after you've finished we'll probably go buy cigarettes.

(Bangladeshi male group: pg. 20/ lines 507-511)

Finally, social functioning was described as a drive to smoke by all the female groups and the Somali male group, who discussed how smoking helped with peer group bonding with existing peers and also with forming new social relationships:

"I think honestly smoking...it's also a social thing... imagine I didn't have a cigarette and my friend had one she'll be like 'oh do you just wanna come' and then she'll just twos [share a cigarette with] me or something, so I think it's also a social thing..."

(Priya, Bangladeshi female group: pg. 101/ lines 2282-2288)

Abdi: When I need a fag yeah and I've got cigarettes in my pockets and a match … and then there's a bunch of girls outside like smoking I would spot a girl and go up to her and say 'have you got a lighter', or you know like.

Taban: It helps to spark a little conversation to be honest.

(Somali male group: pg. 14/ lines 349-352)

3.4.3.1.2. Positive effects of smoking

Positive effects of smoking described by the groups consisted of positive effects on the digestion system. The Bangladeshi male and Somali female group discussed how they perceived smoking to aid with their digestion after eating:

Adan: I think after I eat and I have a cigarette I just feel like 'yeeeah'.

I: Yeah?

Adan: Yeah.

Hasan: Smoking helps you with your digestion man.

Adan: Eh?

Hasan: Smoking helps you digest man.

Adan: Yea, you just feel like chilled.

Hasan: It has a positive effect yeah, if you've got digestion and constipated pain and everything, you smoke, it helps.

Adan: (Laughs) Yeah.

(Bangladeshi male group: pg. 11/ lines 286-295)

Overall it can be seen how the experience of smoking reality can be a positive one and how there can be strong biopsychosocial appeal to remain in the smoking world.

3.4.3.2. Deprived quality of life

All of the focus groups described how smoking deprived their quality of life. This was indicated through their drive for cessation, negative effects of smoking and negative perception of own smoking behaviour. As drive for cessation was discussed earlier in the control theme it will not be discussed here.

3.4.3.2.1. Negative effects of smoking

All of the groups discussed negative effects of smoking. This included negative effects on physical health, physical appearance, personal hygiene and finances. Firstly, with regards to negative effects on physical health, this included minor physical ailments, major physical conditions and difficulties engaging in physical activity. Minor physical ailments included having a bad throat, cough, production of phlegm and impaired sense of smell:

David: And you get a lot of phlegm as well.

Robert: Yea smoking always makes you wanna spit...all the time.

(White British male group: pg. 9/ lines 272-274)

Major physical conditions involved participants acknowledging the more serious longer-term effects of smoking, including accumulation of tar on the lungs, compromised immunity, risk of mouth cancer and effects on mortality and morbidity:

Claire: We might die young.

Tina: True we might die young.

(White British female group: pg. 10/ lines 229-230)

With regards to difficulties in engaging in physical activity, participants from the Somali male group discussed the gradual realisation of experiencing difficulties:

Abdi: And you don't realise it takes an effect on you only when you do certain stuff like for example when I'm running for the bus I'm out of breath, when I get upstairs in the house and I'm out of breath.

Taban: Same here.

Abdi: And I just realised the cigarette actually is taking an effect on me.

(Somali male group: pg. 5/ lines 123-127)

Jack from the White British male group discussed how his difficulty in engaging in physical activity was exacerbated by his pre-existing condition of asthma:

"You get chest pains, breathing difficulties, I got asthma as well so that makes me worse, my throat clogs up now so I can hardly breathe." (Jack, White British male group: pg. 8/ lines 229-230)

Participants from the Somali female and White British male group compared their current fitness levels to their fitness levels in the past, remarking on their reduced capabilities. Comparisons were also made against non-smokers' fitness levels by both of the Somali groups, with females describing their reduced fitness levels as embarrassing:

Amina: Everyone's faster than us...everyone's gone ahead of us.

Nadifa: Climbing up the stairs.

Xaali: Climbing up the stairs!

All: Yea.

Amina: It's a killer.

Xaali: We sometimes sneak in with the teachers to go inside the lift, we say 'ahh miss I've got a bad leg' or something cos the stairs are bare [very] long like.

I: Do you?

Xaali: Yea and you like huff and puff up the stairs, and then it's embarrassing cos like teachers and fat people, not being rude yea...

Nadifa: Can go up the stairs.

Xaali: Are going up the stairs.

I: Yea, how does that make you feel though when you see that?

Xaali: In a way it's kinda embarrassing.

Nadifa: Yea cos you're thinking if people that are older than you and bigger than you can go up stairs, you're a young person why can't you?

(Somali female group: pg. 39-40/ lines 764-783)

Next, both of the Somali and White British groups discussed the effects of smoking on their physical appearance, which included having bad skin and bad teeth. Although the majority of these effects were currently being experienced by the participants, the exception

was wrinkled skin mentioned by the White British female group, which they considered to be a longer-term effect:

Lisa: It ages the skin.

Tina: Yea it makes you have wrinkles.

I: So a few effects then?

Melanie: Yea but not yet.

I: Ok.

Lisa: Yea, I don't really worry about the wrinkle effects now.

Vicky: Yea that's more in the future.

(White British female group: pg. 10-11/ lines 232-238)

Also negative effects on personal hygiene were discussed by all of the groups, which included dirtying of clothes and smelling of cigarette smoke:

"Your clothes get dirty." (Erasto, Somali male group: pg. 26/ line 656)

Finally, negative effects on finances were discussed by all groups, by mentioning smoking being an expensive habit:

"The price, the price of fags, oh my god! If I had every pound I had back yea of all the fags I bought, oh god I'd be a millionaire." (David, White British male group: pg. 10/ lines 278-279)

3.4.3.2.2. Negative perception of smoking behaviour

Negative perception of smoking behaviour was discussed by all of the groups and included i) negative psychological response towards smoking behaviour and ii) change from positive to negative perception of smoking behaviour.

i)Negative psychological response towards smoking behaviour was demonstrated by all of the groups and consisted of having a negative image, negative attitudes and negative feelings towards smoking behaviour. With regards to negative image, this included having a negative image of smoking and negative self-image as a result of smoking. The Bangladeshi male group described having a negative image of smoking, referring to it as a 'curse' and Tina from the White British female group discussed a negative self-image, describing herself as a hypocrite due to defying anti-smoking attitudes held in childhood by smoking.

> "He was the first one. He brought this curse onto all of us [to Adan]." (Zahir, Bangladeshi male group: pg. 3/ line 92)

> "No, I dunno, I just thought it was properly disgusting...and now, and now I feel like a hypocrite myself." (Tina, White British female group: pg. 8/ lines 175-177)

Next, negative attitudes were discussed by all of the groups and were directed towards the effects of smoking and towards initial drive for smoking. Firstly, with regards to negative attitudes towards the effects of smoking, this included towards the physical properties of smoking, including the smoke and the smell along with negative effects on the body including fitness levels and physical appearance:

> "But I hate smoking because it makes your lips darker." (Amina, Somali female group: pg. 38/ line 740)

It also included towards financial and time costs and the influence on young peoples' smoking.

> "It's just money down the drain isn't it?" (Sanchita, Bangladeshi female group: pg. 90/ line 2040)

Next, negative attitudes were also directed towards initial drive for smoking, which were expressed by both of the Bangladeshi groups and the White British male group who reflected negatively on their drive for initiation, describing it as dumb and stupid:

Salman: People that are young they think it's cool.

Adan: They think's it's cool.

Salman: Once they get older they realise it was the most dumbest thing to do, like us.

(Bangladeshi male group: pg. 21/ lines 523-525)

Finally, participants described having negative feelings towards smoking, which consisted of sadness and regret over their smoking behaviour. Firstly, with regards to sadness, Sanchita from the Bangladeshi female group discussed feeling sadness over her smoking behaviour due to her loss of self-identity without smoking:

Sanchita: It's just a routine isn't it? It's just become a routine and I forgot who I would be without them.

I: Why is that?

Sanchita: Because it's been so long since I've not smoked.

I: How does that make you feel?

Sanchita: It makes me sad.

(Bangladeshi female group: pg. 102/ lines 2302-2307)

Next, all the groups described feelings of regret over their smoking behaviour, which arose due to a number of reasons. Firstly, there were feelings of regret over starting smoking:

> "Cos mainly like when you're younger you're more reckless like. You don't really care like. You're just smoking. But thinking about it now I wouldn't have done it in the first place." (Taban, Somali male group: pg. 8/ lines 208-210)

These feelings of regret over starting smoking were sometimes still present despite enjoyment of smoking:

> "If I could turn back time and not smoke I wouldn't do it, even though I enjoy smoking." (David, White British male group: pg. 15/ lines 423-424)

Feelings of regret also resulted due to the effects of smoking on the body and finances and attitudes towards smoking changing:

> "From that first time I really regret it because it ages you and it's not good. It makes your hands smell. It makes you feel sick and it just I dunno, it really makes me sad." (Sanchita, Bangladeshi female group: pg. 8/ lines 201-202)

Finally, getting addicted to smoking and the resulting difficulties in cessation were also causes of the regret:

> "There are times when you think to yourself, and you think if only I never started smoking cos it's so difficult to stop." (Ayan, Somali female group: pg. 40/ lines 784-785)

ii) Change from positive to negative perception was expressed by the Bangladeshi and Somali female groups, who described a change from positive to negative attitudes towards their smoking behaviour. This resulted from not gaining emotional fulfilment from smoking anymore and the initial drive for smoking not being realised anymore:

> "The weirdest part was as I got older it became a not so positive thing. I only felt positive doing it when say I was going out. But otherwise not." (Sanchita, Bangladeshi female group: pg. 49/ lines 1149-1150)

> "...I thought it was like fun to do but now it's like, it's kinda not good, like I don't really like it." (Deeqa, Somali female group: pg. 4/ lines 77-78)

> "Yeah it felt amazing because I felt powerful...I don't know why...But obviously not now. I don't feel powerful anymore doing it." (Sanchita, Bangladeshi female group: pg. 6-7/ lines 165-169)

Overall it is apparent how the experience of smoking reality in the maintenance stage can be a negative one and how far-reaching the impact of negative consequences of smoking behaviour can be in the participants' lives.

3.4.4. Normalisation

The main theme of normalisation referred to normalisation of smoking and consisted of smoking as the norm and smoking as deviant from the norm, which will now be discussed in turn.

3.4.4.1. Smoking as the norm

All of the groups indicated smoking being the norm in their lives. This was illustrated through lack of drive for cessation, drive to smoke, facilitators to smoking freedom, reclaiming smoking freedom, beliefs in smoking as rites of passage, exposure to others' smoking, acceptance of others' smoking and belief in equilibrium between smokers and non-

smokers. As lack of drive for cessation, drive to smoke, facilitators to smoking freedom and reclaiming smoking freedom were discussed earlier in the freedom and control themes, they will not be discussed here.

3.4.4.1.1. Belief in smoking as a rites of passage

Firstly, with regards to beliefs in smoking as a rites of passage, participants from both of the White British groups, the Bangladeshi female group and Somali male group believed smoking to be a natural part of growing part:

David: It's just natural.

Robert: I reckon every person is going to try a fag once in their life.

I: Yea?

Robert: It's like so common.

(White British male group: pg. 21/ lines 613-616)

3.4.4.1.2. Exposure to others' smoking

Next, exposure to others' smoking consisted of perception of high smoking prevalence around self and experience of hardened smokers. Firstly, with regards to perception of high smoking prevalence around self, this was expressed by all the groups and consisted of perception of high smoking prevalence amongst the family, peers and wider community. The White British groups and both of the Bangladeshi groups spoke of the whole family or majority of the family smoking:

"All my family smokes except for my niece, my nephews." (Vicky, White British female group: pg. 6/ line 112)

High smoking prevalence amongst peers was expressed by all the groups except the Somali male and White British female groups. This consisted of the whole peer group or the majority

of the peer group smoking and the Somali female group having a perception of high smoking prevalence amongst Somali males:

> "No. There's a group of us, about 10, 11 of us and most of us, I'll say 99 per cent of us smoke." (Adan, Bangladeshi male group: pg. 24/ lines 606-607)

> "They all smoke, all Somali boys smoke." (Nadifa, Somali female group: pg. 49/ line 960)

Finally, high smoking prevalence within the wider community was firstly stated by the Somali female group, who referred to high prevalence of smoking within their educational establishment:

> Nadifa: A lot of people smoke now, during college and stuff.
>
> Ayan: Yea the majority man.
>
> Nadifa: They all smoke, in college everyone.
>
> Ayan: 99% in college.
>
> (Somali female group: pg. 11/ lines 202-205)

Also the Bangladeshi male group discussed high smoking prevalence within the local community and also in general society, whereby they over-estimated the national smoking rate:

> Salman: Do you know the number of people that smoke in this country? I dunno.
>
> I: Now it's about 23 per cent.
>
> Taban: That's like not most of the population. That's like a quarter.
>
> Zahir: That's quite lower than I thought.
>
> Taban: Yea but poor people can't afford it as well.

Hasan: Just a quarter?

I: Yea it's just under a quarter of the population.

Zahir: Is that it?! I would have thought more.

Adan: Yea.

(Bangladeshi male group: pg.15/ lines 381-389)

Finally, the Bangladeshi and Somali male groups discussed beliefs in increasing smoking prevalence in society:

Dalmar: I think now, over previous times, more people tend to smoke. I definitely think more people are smoking nowadays.

Abdi: Course they do, we know that.

Dalmar: If I went into [redacted] Street yeah in 2001 and video recorded everyone yeah, I'd probably only see 3 or 4 people smoking but if you go to [redacted] Street now the chances are you'll see the whole of [redacted] Street smoking.

I: So you think more people are smoking?

Dalmar: More people. Yeah.

(Somali male group: pg. 32/ lines 808-815)

Next, with regards to experience of hardened smokers, all the female groups and the Bangladeshi male group spoke of exposure to unsuccessful quitters in their life and also refusal of other smokers to quit:

Vicky: My dad has, my dad actually stopped but then his dad died so he started again.

I: Right ok

Tina: Yea mine as well. My dad stopped for about 2 years but then he went into hospital and then he came back out and started smoking again...I think the longest that my family has ever stopped smoking is my dad's two years.

(White British female group: pg. 17/ lines 388-394)

3.4.4.1.3. Acceptance of others' smoking

Acceptance of others' smoking was discussed by the Bangladeshi female group and consisted of acceptance of smoking peers' smoking behaviour and encouragement of non-smoking peer's interest to smoke:

Dipika: I don't care what they do [laughs], they're friends aren't they?

Mala: I was like 'whoa if you wanna smoke, smoke'.

(Bangladeshi female group: pg. 19/ lines 460-461)

"I got kicked out of that [school] and I went to another one and then I started getting my friends into it! Then my friends started smoking as well. And then I remember my best friend she used to not smoke and so then she used to tell me to teach her how to smoke...So like I used to be like 'pull it in, just keep it, inhale it properly' and she used to cough and stuff and say 'how'd you do it?!' Then I was just like 'do it properly' and she used to just laugh and she could never do it. She still can't do it!" [laughs]. (Anjali, Bangladeshi female group: pg. 12/ lines 281-288)

3.4.4.1.4. Belief in equilibrium between smokers and non-smokers

Belief in equilibrium between smokers and non-smokers was expressed by all of the groups except the Bangladeshi male group. Although surface distinctions were drawn

between smokers and non-smokers regarding better health and hygiene, core elements were considered the same, with non-smokers being described as ‘normal’ and ‘the same’:

> Lisa: They’re just the same except that they don’t smoke.
>
> Vicky: Exactly the same.
>
> I: Yea?
>
> Lisa: Nothing wrong.
>
> Claire: And they don’t smell of cigarettes.
>
> Vicky: And yet they don’t stench of it, like.
>
> (White British female group: pg. 15/ lines 346-351)

Also, although praise was given to non-smokers for not smoking, this was superseded by comments on other substance use they employed or on how this did not detract from the positive qualities of smokers, again indicating a belief in lack of distinction between the two groups:

> “Nothing. They’re the same as people who smoke. There are people who drink as well. There are people who don’t smoke cigarettes but smoke weed. So like I’m not really there to judge people, their views or whatever, it doesn’t bother me. Cos I know I’ve got my own views. I know other people got their own views. They won’t see it as the same way as I do. People do things according to their own devices, it doesn’t bother me.” (Anjali, Bangladeshi female group: pg. 89/ lines 2004-2008)

Overall it is apparent how the smoking world can be interpreted as the norm by participants during the maintenance stage of the smoking process.

3.4.4.2 Smoking as deviant from the norm

All of the groups indicated smoking being deviant from the norm. This was illustrated through drive and intentions for cessation, barriers to smoking freedom, relinquishing freedom to smoke, belief in smoking not being a rites of passage, exposure to non-smokers, rejection of others' smoking and positive perception of non-smokers due to non-smoking behaviour. As drive and intentions for cessation, barriers to smoking freedom and relinquishing freedom to smoke were discussed earlier in the freedom and control themes, they will not be discussed here.

3.4.4.2.1. Belief in smoking not being a rites of passage

Participants from all of the female groups discussed smoking not being the norm for individuals growing up, with the Bangladeshi female group discussing peers who did not smoke and possible reasons for this.

"No I don't think it's normal for kids to grow up smoking." (Melanie, White British female group: pg.17/ line 397)

Mala: Yea because her [non-smoking peer's] friends didn't smoke.

Priya: yea, exactly.

Mala: She wasn't in the right environment where people smoke.

Dipika: Some people just really can't stand the smell or anything.

(Bangladeshi female group: pg. 100/ lines 2251-2254)

3.4.4.2.2. Exposure to non-smokers

Exposure to non-smokers consisted of perception of low smoking prevalence around self and experience of successful quitters. Firstly, with regards to perception of low

prevalence of smoking around self, participants from the Somali female group commented on the low prevalence of smoking amongst their family and amongst Muslim girls as a whole:

> "The issue is like most, like, Muslim girls don't smoke..." (Deeqa, Somali female group: pg. 28/ line 557)

Next, with regards to experience of successful quitters, this included exposure to successful quitters and influence of exposure to successful quitters. Firstly, exposure to successful quitters was relayed by both of the Bangladeshi groups and the Somali female group, who recounted stories of people in their lives including peers, acquaintances and family members that had quit successfully:

> "...I had a friend she's a hairdresser and she smoked all the time. Any minute she got cos hairdressing's just as stressful isn't it? Yeah when someone's in the chair you gotta make conversation with them and you're not really bothered but you have to do it cos you know these are your clients isn't it and she just got so stressed and she used to be a very edgy person. Very very edgy and then like she just quit! It was just cold turkey. There wasn't anything like sweets with her or any help she was 'right that's it, stop and finished!' and til today she's smokefree." (Sanchita, Bangladeshi female group: pg. 84/ lines 1907-1914)

Ayan from the Somali female group also commented on her exposure to a high frequency of successful quitters:

> "Yea I know loads of people that have stopped."(Ayan, Somali female group: pg. 63/ line 1243)

With regards to influence of exposure to successful quitters, this was mentioned by the White British male, Somali female and Bangladeshi female groups. Influence of exposure to successful quitters included impacting on beliefs on effective cessation methods, methods used for own cessation behaviour and self-efficacy regarding cessation:

> "I think if you're more heavy it would be harder obviously cos it becomes routine but yea I think if you're not a heavy smoker then in a way I think it'll be alright but because of what happened to my uncle in January and he was a heavy smoker so I think anything is possible." (Priya, Bangladeshi female group: pg. 79/ lines 1796-1799)

3.4.4.2.3. Rejection of others' smoking

Rejection of others' smoking consisted of discouraging non-smoking peers to smoke and encouraging cessation amongst smoking peers and family members, which was mentioned by the Bangladeshi female and Somali female group.

> "But sometimes because they [male peers] are Somalian, sometimes you tell them we both need to stop [smoking]..." (Ayan, Somali female group: pg. 49/ lines 971-972)

3.4.4.2.4. Positive perception of non-smokers due to non-smoking behaviour

The Somali male, White British male and Bangladeshi female group expressed positive attitudes towards non-smokers as a result of their non-smoking behaviour and Sanchita from the Bangladeshi female group expressed how her attitudes had changed from negative to positive over the course of her smoking behaviour@

Robert: Probably, they were just smart.

I: Smart in what way?

Jack: Like not spending their money.

David: Yea like they spend their money on other stuff, they knew the risks.

(White British male group: pg. 14-15/ lines 420-423)

Abdi: I think it's good for them.

Erasto: I think good on you.

Ghedi: I rate them highly.

Roble: Yea same.

Dalmar: I rate them very highly, do you know why? They can play football 90 minutes non-stop without going (pants). We take one shot and we either get a cramp or our chest hurts.

(Somali male group: pg. 25/ lines 623-629)

Sanchita: When I was younger I was only with smokers, that's the funny part.

I: Ok how did you view non-smokers?

Sanchita: They weren't cool....They weren't cool. They weren't fun....Now I think they're amazing people. [Laughs] I wish I was one of them.

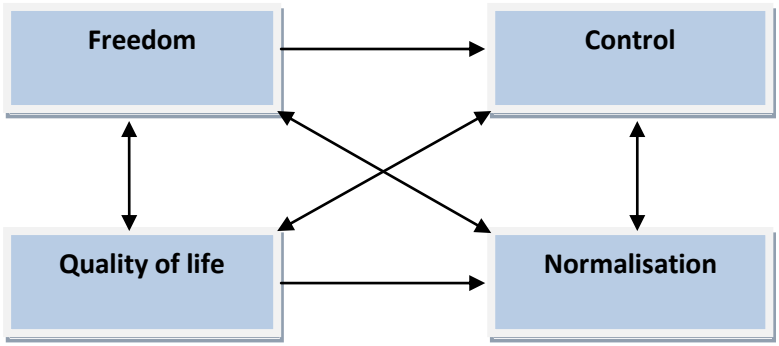
(Bangladeshi female group: pg. 89/ lines 2010-2020)

Overall it can be seen how smoking behaviour can be viewed as not representing the norm for participants in the maintenance stage, as a result of the impact of non-smoking influences in their lives.

3.4.5. Summary of the maintenance stage

Overall the main themes of ‘freedom’, ‘control’, ‘quality of life’, and ‘normalisation’ constituted the core category of ‘negotiating smoking reality’ for the maintenance stage. At this stage of the smoking process participants were managing their own smoking realities, which for some involved a desire to revert back to a non-smoking world and for others to remain in the smoking world. The figure below highlights the links between each of the main themes in the maintenance stage:

Figure 3.6. **Links between the Main Themes for the Maintenance Stage**



It can be seen from the figure above that normalisation of smoking, which consisted of smoking being the norm or deviant from the norm, impacted on participants’ freedom to smoke and on the control of their smoking behaviour. For example, those participants who viewed smoking as the norm may have wanted to reclaim freedom over their smoking behaviour and not wished to regain control over their smoking behaviour by quitting.

Next, freedom of smoking behaviour, which consisted of barriers and facilitators to freedom and reclaiming and relinquishing freedom, impacted on control, quality of life and normalisation. For example, those participants who relinquished freedom to smoke may have also wanted to regain control over their smoking behaviour as a result of deprived quality of life and viewing smoking as deviant from the norm.

Next, control of smoking behaviour, which consisted of loss of control and regaining control, impacted on quality of life and normalisation. For example, those participants who experienced loss of control over smoking behaviour may have experienced a deprived quality of life and viewed smoking as deviant from the norm.

Finally, quality of life, which consisted of enhanced and deprived quality of life impacted on freedom, control and normalisation. For example, participants with enhanced quality of life may have reclaimed freedom to smoke, not wanted to regain control of smoking behaviour and viewed smoking as the norm.

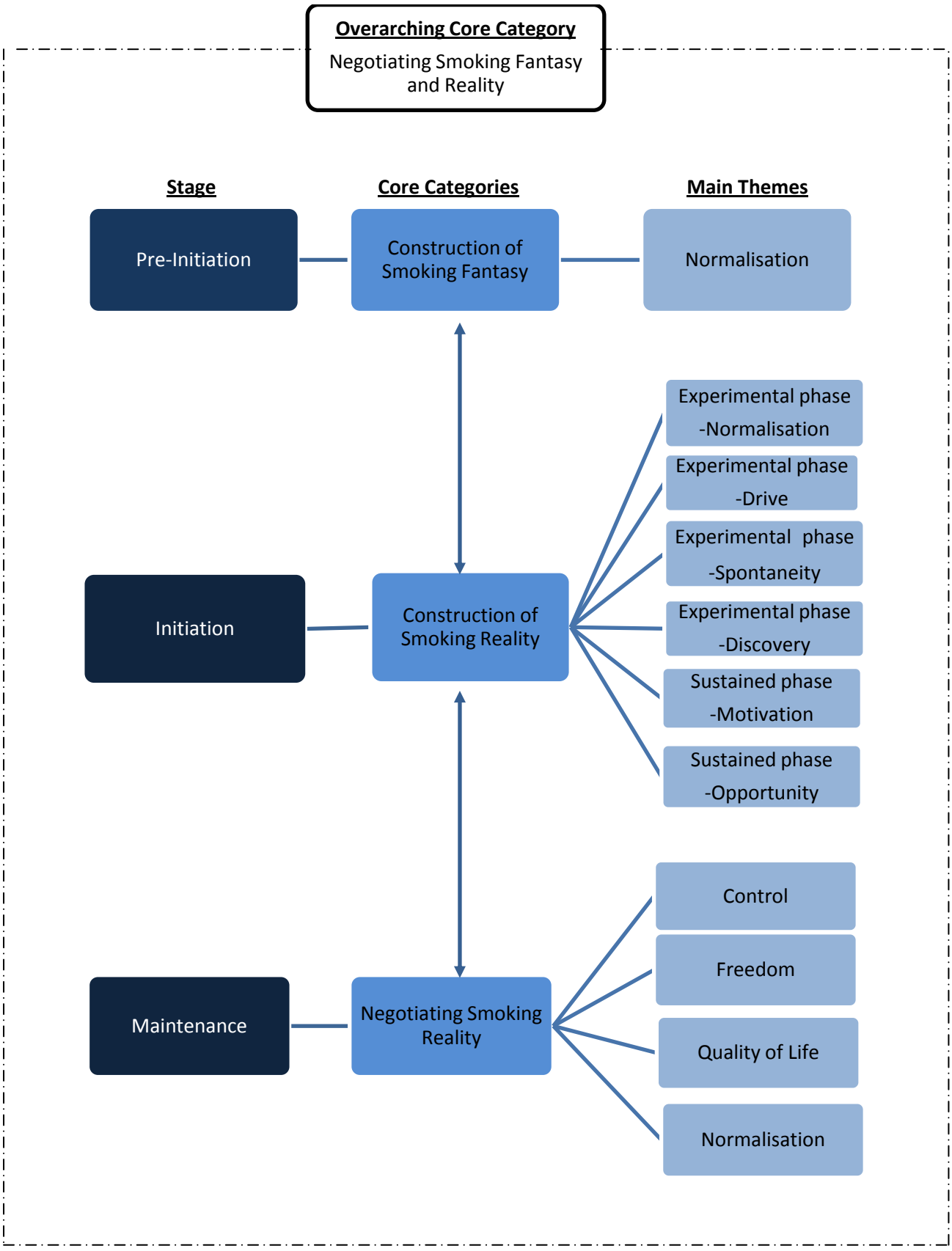
Overall the themes of quality of life and freedom to smoke impacted the most on the other themes in the maintenance stage.

3.5.Summary of the core categories

The core categories for each of the three stages of the smoking process consisted of ‘construction of smoking fantasy’, ‘construction of smoking reality’ and ‘negotiating smoking reality’. The overarching core category for all three stages of the smoking process from pre-initiation to maintenance was ‘negotiating smoking fantasy and reality’. These are highlighted in figure 3.7 along with the main themes for each of the core categories.

Overall the smoking process from initiation through to maintenance and cessation involves participants negotiating their earlier fantasies of the smoking world with later realities. This process of negotiation is an ongoing process as smoking reality appears to be in a state of permanent flux dependent on a complex interplay of social, physiological and psychological forces, which have been identified within each of the themes.

Figure 3.7. **Summary of the Core Categories and Main Themes**



CHAPTER 4

DISCUSSION

Overall it can be seen how the experience of pre-initiation, initiation, maintenance and cessation for young people from Bangladeshi, Somali and White British ethnic backgrounds was shared through the three individual core categories of, 'construction of smoking fantasy', 'construction of smoking reality' and 'negotiating smoking reality', and the overarching core category of 'negotiating smoking fantasy and reality'. However, within this shared experience there were also distinctions between the groups. These shared and distinct experiences for each stage of the smoking process will now be discussed in relation to findings from the literature review outlined in the introduction.

4.1.Pre-Initiation Stage: Construction of smoking fantasy

4.1.1. Normalisation

The findings showed how smoking became normalised through childhood exposure to familial smoking for all of the groups and to a lesser degree through exposure peer smoking, which was only stated by participants from the Bangladeshi female and Somali male group. This relates with discussion in the literature review regarding familial influence being an important influence at the preparation stages of smoking, with curiosity being sparked and normative beliefs being formed (DeLorme et al., 2003; Milton, Woods, Dugdill, Porcellato & Springett, 2008; Greenlund, Johnson, Webber & Berensen, 1997; Ajzen, 1991). Mention of familial exposure to smoking by all the groups could be linked to the fact that the study was conducted in a deprived inner-city area because, as was discussed in the introduction, adult

smoking rates are correlated with social and economic deprivation (Office for National Statistics, 2009; Jarvis, Wardle, Waller & Owen, 2003).

It was demonstrated in the study how feelings of curiosity and wonderment at familial smoking, along with partaking in and emulating parental smoking rituals, illustrated a childhood acceptance of the smoking world. Also, with regards to the formation of normative beliefs, the study showed how exposure to female familial smoking for the Bangladeshi female group led to the development of female smoking gender norms, which were in contradiction to existing traditional norms regarding the acceptance of female smoking in Bangladeshi culture. Markham, Featherstone, Taket, Trenchard-Mabere and Ross (2001) had discovered that young Bangladeshi boys often learnt to smoke by observing male elders, and from this study it could be argued that the same phenomenon is occurring with Bangladeshi girls, through the observation of female elders. The majority of Bangladeshi female participants in this study described elder female family members smoking and although this was often a covert activity, which still indicates the taboo nature of female smoking, it was still prevalent. This could lend support to the argument discussed in the literature review that there may be under-reporting of smoking behaviour by Bangladeshi women (The National Health Service [NHS] Information Centre, 2006; Pooransingh & Ramaiah, 2001) or this could be a generational shift, whereby from a Social Learning Theory perspective (Bandura, 1977), the first wave of second generation smokers, such as those reported in Markham's study, are now becoming the parental smoking role models for this present generation.

As well as indications of smoking being the norm during the pre-initiation stage, there were also indications of smoking being deviant from the norm. All of the groups described childhood rejection of the smoking world, which mainly resulted from perceived negative effects of smoking, such as the smell and health risks. The Bangladeshi female group also described having a negative image of female smokers, due to their defiance of traditional

smoking gender norms. Hence it can be seen how traditional gender smoking norms can be firmly embedded within young Bangladeshi females during the pre-initiation stage. Research has shown that young children generally emphasise that smoking is bad (Hahn et al., 2000; Porcellato, Dugdill, Springett & Sanderson, 1999; Porcellato, Dugdill & Springett, 2005). Also children of non-smoking parents have been found to display less tolerant attitudes towards smoking and are less likely to express a desire to smoke in the future than children with smoking parents (Brook, Mendelberg, Galili, Priel & Bujanover, 1999; Shute, St. Pierre & Lubell, 1981; Porcellato, Dugdill, Springett & Sanderson, 1999). This was supported by findings in this study, where it was found that some participants from both of the Somali groups had complete non-smoking households and expressed how their anti-smoking attitudes and lack of intentions to smoke arose from the influence of non-smoking parents. It was even demonstrated by groups, such as the White British female group, that having one non-smoking parent could lead to non-smoking intentions.

However, it was also shown by all of the groups that participants with high exposure to familial smoking also held negative attitudes towards smoking, lack of intentions to smoke and desired cessation among family members. This presence of negative attitudes and lack of intentions to smoke amongst participants from both smoking and non-smoking families, indicates that a shift occurs during the pre-initiation to initiation stage. Anjali from the Bangladeshi female group described how she gained increased tolerance to the smell of cigarettes due to repeated exposure to her uncle's smoking. This desensitisation to smoking, due to repeated exposure, helps highlight some of the processes involved that could be responsible for this shift. Again this supports the argument of how exposure to familial smoking can start to establish smoking norms, which in turn can start to impact on preparation to smoke. So for example, although some participants from the Bangladeshi female group initially demonstrated a non-smoking norm by wanting family members to quit

smoking (due to religious beliefs and health concerns), they were exposed to an alternative smoking norm when being confronted with smoking elders who did not share these beliefs and refused to quit smoking.

Also De Leeuw, Engels and Scholte (2010) argue that whether young children perceive the smoking behaviour as belonging to them or others can also have an impact. So for example, when Bharati from the Bangladeshi female group expressed desire for her mother's cessation in childhood due to her mother borrowing money for cigarettes, it could be argued that this negative experience of smoking and the negative attitudes assigned to smoking as result were just assigned to her mother's experience and not necessarily her own journey of smoking. Hence this negative experience of her mother's smoking would not necessarily impede her own intention to smoke in the future.

These findings support the notion that parental smoking is often considered the first influence on experimentation with cigarettes, particularly for younger children (Charlton et al., 2010). DeLorme et al. (2003) suggest that familial influences are more pertinent that peer influences in the early preparation stages of smoking, which is indicated in this study, and that their effects are cumulative. So for example, there is repeated exposure to smoking in the family, the curiosity factor resulting from observing family members smoking and easy accessibility to cigarettes, which also seems represented in this study.

4.2. Initiation Stage: Construction of smoking reality

4.2.1 Experimentation phase: Normalisation

Again normalisation was indicated by all of the focus groups, but at this stage it was mainly as a result of exposure to peer smoking. Even the two smoking family members

discussed by the Bangladeshi female group (cousin and uncle) had a peer like relationship with the participants. All of the groups described how some or the majority of their peer group smoked and Dipika from the Bangladeshi female group also mentioned having two distinct peer groups based on smoking and non-smoking status, which relates to Denscombe's (2001) findings in the literature review regarding the multiplicity of peer groups and the flexibility of their composition. The Somali male and Bangladeshi female group remarked on the negative image they had of non-smoking peers in comparison to smoking peers, which even led to some participants in the Bangladeshi female group not associating with non-smokers. This supports the findings of Spijkerman, Van Den Eijnden and Engels (2007) that adolescent smokers are more likely to perceive their non-smoking peers in a less favourable light and are more likely to join a peer group with smoking members, in order to become associated with the more favourable images.

4.2.2. Experimentation phase: Drive

Drive to smoke included internal and external drives.

4.2.2.1. Internal

Internal drives to smoke firstly involved wanting to enhance social identity. This was indicated through wanting to attain a specific image, such as being cool or adult-like, which supports Erikson's (1950) claim of smoking experimentation being part of a search for identity and other research purporting the construction of young peoples' image or identity through smoking (Scheffels, 2009; DeLorme et al., 2003; Moffat & Johnson, 2001). It was also indicated through wanting to bond with the peer group, which also supports findings from previous research with the general population (Conrad, Flay & Hill, 1992; DeLorme et

al., 2003; Moffat & Johnson, 2001; Alexander et al., 1999; Nichter et al., 1997). Also this indicates the importance of peer influences at the time of experimentation.

State characteristics were also expressed as a drive. Firstly, this included states of curiosity and wonderment, which were stated by the Bangladeshi female, Somali female, White British male and Bangladeshi male groups, and resulted from peer and familial smoking. Previous research has considered curiosity resulting from peer smoking being instrumental in experimentation (DeLorme et al., 2003; Moffat & Johnson, 2001; Lloyd & Lucas, 1999; Milton et al., 2008). However, in this study wonderment from female familial smoking was also described by the female Bangladeshi group, indicating the impact that female smoking familial influence can have on experimentation for this group. This again could be attributed to the fact that exposure to female familial smoking was one of the first experiences of exposure to female smoking for some of the Bangladeshi female participants due to it being taboo, and hence held a sense of fascination and wonderment. Next, a state of insecurity was described by the female Bangladeshi female group, which in turn led to wanting to enhance social identity within the peer group. This supports findings from Moffat and Johnson's study (2001) carried out with White British female participants, whereby participants who sought peer group or approval were motivated by insecurity. Also states of recklessness and sensation seeking, which involved smoking as an act of daring, fun and rebellion against parental rules, were described by both of the Somali groups and the Bangladeshi female groups, which supports findings for the general population regarding experimentation being associated with novelty seeking personality characterised by sensation seeking behaviour (Wills, Vaccaro & McNamara, 1994; Wills, Windle & Cleary, 1998; Masse & Tremblay, 1997; Lloyd & Lucas, 1998) and being an act of rebellion against parental rules (DeLorme et al., 2003).

Trait characteristics represented the largest distinction between the White British and the other groups. They were discussed by both of the Somali and the Bangladeshi groups but not the White British group and involved weakness of character (being easily influenced by peers and having a lack of willpower to resist temptation to smoke), stupidity and naiveté of youth. These traits tended to represent the self and the process of experimentation in a disparaging light, which may have resulted from current negative attitudes towards smoking or a reflection of previous negative attitudes and lack of intentions to smoke in the pre-initiation stage.

Experimenting to use smoking as a coping mechanism was stated by the White British male, Somali male and Bangladeshi female groups, which supports research done with the general population where high stress levels have been found to correlate with initiating smoking (DeLorme et al., 2003; Croghan et al., 2006). Stressors in this study included family conflict, school stress and general social pressures, which reflected what Moffat and Johnson (2001) discovered in their study with young White British female participants.

The White British male and Bangladeshi female group specified the importance of individual desire and choice for experimentation, regardless of external pressures such as peer pressure, which fits into previous research conducted with the general population that indicates that young people reject the idea of being the victims of peer pressure (Nichter et al., 1997; Denscombe, 2001).

Beliefs on smoking as an internal drive for experimentation were also illustrated. These included health beliefs, which were stated by the Bangladeshi male, White British male and Somali female groups and religious beliefs, which were described by the Bangladeshi female group. Health beliefs were related to being exposed to passive smoking, perceived insusceptibility to getting addicted and perceived insusceptibility to suffering smoking health risks. All of these health beliefs arose after exposure to peer smoking, which

again indicates the important of peer influence on experimentation. With regards to beliefs on passive smoking, the Bangladeshi male and Somali female groups described how being exposed to passive smoking as a result of peers' smoking can lead to self-smoking. This 'if you can't beat them, join them' attitude appears to represent a state of cognitive dissonance (Festinger, 1957; Wicklund & Brehm, 1976), whereby initially it appears participants had conflicting views over smoking but then decided to join their peers as this potentially was the path offering least resistance.

With regards to perceived insusceptibility to addiction, participants from the White British male and Somali female group described how they were unaware of getting addicted at experimentation, which supports the viewpoint that young people who start smoking are unaware of the risk of addiction (Slovic, 2001). However, Deeqa from the Somali female group was warned about the risk of addiction by peers but believed herself to be immune. This indicates an optimism bias and supports research which has shown that adolescent smokers believe the health risks of smoking are lower for themselves than for other same-age smokers (Weinstein, 1998). Participants from the Somali female group also expressed perceived insusceptibility to suffering from smoking health risks due to observing the good health of smoking peers. In both regards (with perceived insusceptibility to addiction and smoking health risks) this indicates that perceived susceptibility (Rosenstock, 1966) to risks of smoking was low.

Religious beliefs were mentioned by the Bangladeshi female group, whereby Mala purported to manipulate Islamic religious doctrine to support her experimentation. This again indicates attempts to resolve cognitive dissonance (Festinger, 1957; Wicklund & Brehm, 1976). Dissonance was created due to religious beliefs opposing smoking and experiencing desire to smoke, which consequently was resolved through justifying smoking behaviour by re-interpreting religious doctrine.

Change from non-smoking to smoking intentions were described by both of the Somali groups. Firstly, this change resulted from issues concerning identity, for example, the Somali male group described how they linked smoking with the identity of 'getting older'. This relates with research discussed in the literature review with the general population, whereby experimentation has been linked with asserting adulthood among young people (Jarvis, 2004; Mullen, 2000; Scheffels, 2009). Also both Somali groups mentioned enhancing social identity, which was discussed earlier in internal drive for experimentation. Change also resulted from health beliefs, which were discussed earlier. Next, becoming desensitised to smoking was stated by the Somali female group, which relates to findings discussed in the pre-initiation stage for the Bangladeshi female group, whereby increased tolerance to the smell of smoking was developed after exposure to familial smoking. In this case tolerance was developed due to a combination of peer and sibling smoking. Generally all of these changes in intentions were the result of exposure to peer and sibling smoking, which again lends credence to the important influence of peer smoking and in this case, also siblings' smoking on experimentation. The fact that the Somali groups highlighted a shift in intentions illustrates how there was a significant change in their attitudes towards and norms regarding smoking as a result of exposure to others' smoking, especially given that some participants from these groups were the only ones to indicate coming from complete non-smoking households.

Next, modelling the smoking behaviour of others, including family members and strangers, was mentioned by all of the groups. The Bangladeshi male group also discussed how modelling of smoking behaviour by a peer was reinforced vicariously through observing his Imam receiving physical reward. Both cases support the concept of Social Learning Theory (Bandura, 1977), whereby individuals learn behaviour through observation of social

influences. Also this indicates that familial influence and societal influences can also have an impact on experimentation in addition to peer influences.

Engagement in other substance use as a drive for experimentation was discussed by the Somali male group in relation to a peer. The substance use consisted of smoking cannabis with tobacco, which was considered to lead onto smoking cigarettes. The reverse gateway theory, which proposes that cannabis use can lead into smoking cigarettes, has been researched but results are inconclusive due to cannabis often being mixed with tobacco (Patton et al., 2005). However, cannabis has been referred to as a 'trojan horse' for nicotine addiction as a result of this mixing of the two. (Ministerial Council on Drug Strategy, 2005).

4.2.2.2. External

Firstly, external drive for experimentation comprised of peer group influences, which included being offered cigarettes by peers and verbal insistence to smoke by peers. This again highlights the importance of peer smoking on experimentation. Being offered cigarettes by peers was mentioned by the White British male and Bangladeshi female group. Verbal insistence to smoke by peers was mentioned by all of groups, except the White British female group. The study conducted by Alexander, Allen, Crawford and McCormick (1999) found that very few of their teen participants described peer pressure when recalling the circumstances of their smoking initiation and the rare times direct pressure had been described it was by males. However, in this study the Bangladeshi female and Somali female groups also described experiencing it, which does not indicate a gender effect across cultural groups.

Parental influences were discussed by the all of the female groups and firstly included lack of parental deterrent to smoke, which was mentioned by the Bangladeshi female group in reference to smoking mothers. This supports the notion discussed earlier that parental

attitudes can be considered a risk factor for young people to start smoking (British Medical Association Board of Science, 2007), whereby the more likely children anticipate disapproval and negative attitudes for smoking from their parents the less likely they are to become smokers (Jackson & Dickinson, 2006; Aaro, Haukness & Berglund, 1981). The Somali female group described how bad parenting in the form of having low and negative expectations of children resulted in a self-fulfilling prophecy, which illustrates how parenting practices can impact on young peoples' engagement in risky behaviour like smoking. Finally, the White British female group discussed how parental smoking was responsible for their experimentation by describing how their parents had initiated a cycle of smoking as a result of having smoked in front of them as children, which relates to the notion of parental smoking increasing the risk of smoking in children (Royal College of Physicians, 2010).

Overall as a result of attributing external drive for experimentation it can be argued that these participants indicated an external locus of control (Rotter, 1954) over experimentation as opposed to those expressing internal drive to smoke. Participants from all the groups demonstrated a combination of internal and external locus of control over experimentation.

Also researchers have argued that peer influences are more instrumental than familial influences at the time of experimentation (DeLorme et al., 2003), which appears to be supported in this study, although familial influences were also still apparent.

4.2.3 Experimentation phase: Spontaneity

Participants from the Bangladeshi female, White British male and Somali male groups described spontaneous experimentation, which was firstly triggered through opportunistic access to others' cigarettes. This involves being offered by cigarettes by peers and

acquaintances and accidently discovering cigarettes belonging to family members. This supports the view that exposure to others' smoking can present opportunity for experimentation due to the availability of cigarettes (DeLorme et al., 2003; Arnett, 2007). Spontaneous experimentation was also attributed to impulsivity to smoke by the Bangladeshi female group. The spontaneous nature of experimentation for some participants supports findings from other research indicating that experimentation among adolescents is unplanned behaviour (Kremers et al., 2004). Such findings suggest the importance of considering unconscious as well as conscious processes that occur at the time of experimentation.

Participants from all the groups also demonstrated pre-meditated experimentation through prior accessing of cigarettes via purchasing from shops and requesting cigarettes from peers. Requesting cigarettes from peers at the time of experimentation supports findings by Hahn et al., (1990), whereby smokers that initiated smoking in the presence of other smokers, asked for a cigarette rather than having it suggested to them.

Finally, preparation for experimentation was expressed by the Bangladeshi female group, which involved taking cautionary measures with location when smoking to avoid discovery by teachers and parents. This supports findings by DeLorme et al. (2003) where participants also engaged in rituals to conceal their smoking behaviour from their family at the time of initiation. However, in this study this also extended to teachers for the Bangladeshi female group because experimentation was also undertaken at school.

4.2.4 Experimentation phase: Discovery

Firstly, psychological discovery included behavioural discovery, which was highlighted by all the groups except the White British male group, in the form of acclimatising to the technique of smoking during experimentation. The input of peers into

this process was highlighted by the White British female and Somali group in the form of observing peers to learn the technique and peers also actively assisting participants with the technique.

Psychological discovery also consisted of positive and negative psychological responses. With regards to positive responses, Sanchita from the Bangladeshi female group spoke of how she felt cool when smoking (although this effect was only confined to when engaging in the act and not afterwards). Other positive responses resulted from the physiological effects of smoking, which were described by both of the Somali groups and the Bangladeshi female group and also from fulfilment of drive for experimentation, which was expressed by both of the Bangladeshi groups and the Somali female group. All these positive responses during experimentation had important implications for sustained smoking which will be discussed later.

On the reverse side, negative psychological responses were also experienced during experimentation. Firstly, these responses consisted of feeling fearful and sinful due to anticipated parental disapproval of experimentation, which was mentioned by the White British male and Bangladeshi female groups. This indicates how anti-smoking familial attitudes can affect young people when they are undergoing experimentation and supports findings from DeLorme et als' study (2003) where young people also talked of experiencing guilt and fearing their parents' reactions. The Somali male group described feelings of hypocrisy which resulted due to earlier non-smoking intentions, which suggests there can be a degree of inner-conflict that occurs at the time of experimentation for individuals who previously held anti-smoking attitudes. Fear was described by the Somali female group in response to undertaking the act of smoking for the first time.

Negative psychological responses also occurred after engaging in the act. These included feelings of embarrassment in front of peers due to lack of mastery over technique,

which was described by the Bangladeshi female and Somali female groups. Also negative response to physiological effects was described by all of the groups. This in turn impacted on lack of intentions to smoke again for participants in both of the Somali groups. This suggests how there can be unanticipated consequences to experimentation and how the process does not necessarily live up to expectations or go according to plan, which also supports findings from other studies (DeLorme et al. 2003).

Physiological discovery was highlighted by all the groups and consisted of physical symptoms and physical sensations experienced when engaging in the act of smoking, which ties in with findings from other research (Hirschman, Leventhal, & Glynn, 1984; Pomerleau, Pomerleau, & Namenek, 1998).

4.2.5 Sustained smoking phase: Motivation

After the initial phase of experimentation it was discovered how some participants had a longer wait before smoking again whereas others continued smoking from the moment of experimentation.

Motivation for immediate and shorter-term sustained smoking was both similar to and different from drive for experimentation. Similarities included smoking to enhance social identity, using smoking as a coping mechanism for stress, smoking as an act of rebellion, trait characteristics and smoking health beliefs, which were discussed earlier.

Differences to drive for experimentation related to the experience of experimentation. This included gaining emotional pleasure from smoking and to practise smoking technique. Gaining emotional pleasure from smoking was mentioned by all of the focus groups, which supports other findings stating that the positive pleasant effects of smoking experienced during initiation have a strong association with later smoking behaviour (Eissenberg &

Balster, 2000). Practising smoking technique was mentioned by the Bangladeshi female and Somali female group and was often fuelled by enhancing social identity within the peer group, which was somewhat damaged by the negative and embarrassing experiences of experimentation. This illustrates how peer group influences can be a strong reinforcing force for sustained smoking when initial experience of experimentation was negative.

Motivation for longer-term sustained smoking was expressed by the Bangladeshi female group and involved using smoking as a coping mechanism for stress and social anxiety and for peer group bonding. Participants from the Bangladeshi female group frequently discussed experiencing familial conflict, which led to smoking being used as a coping mechanism during both experimentation and also sustained smoking. This also fed into using smoking as an act of rebellion against parents, which again was a drive for their experimentation and initiation. This supports findings of Markham et al. (2001) who also found motivation to smoke for young Bangladeshi females centred on issues regarding rebellion against parental expectations.

4.2.6 Sustained smoking phase: Opportunity

Participants from all groups highlighted being granted opportunity to smoke during the sustained smoking phase. Firstly, this involved through being able to access cigarettes despite being underage. Sources of access included stealing from family members, asking others (peers, family members, strangers on the street) to purchase cigarettes, sharing peers' cigarettes and being served in shops. This highlights how social influences in the form of family, peers and the wider community can perpetuate smoking for young people in the sustained smoking phase, which relates to findings in the introduction on how peers, family members and retailers have an important role in youth access to cigarettes (Gilpin et al.,

2001; National Institute for Health and Clinical Excellence, 2008; The NHS Information Centre, 2009).

The White British male group also reported how sometimes they were denied opportunity to smoke by strangers refusing to purchase cigarettes, which indicates the sometimes 'hit and miss' nature of these sources.

Next, being granted opportunity to smoke involved being able to smoke at school due to lack of anti-smoking measures and lack of enforcement of non-smoking policy, which was mentioned by all of the groups apart from the Somali female and White British male group. This relates with findings discussed earlier regarding the importance of comprehensive anti-smoking policies combined with sufficient enforcement to create an environment where smoking is not deemed seemed safe, acceptable or the norm (Moore, Roberts & Tudor-Smith, 2001; Wakefield et al., 2000; Poulsen et al., 2002; Charlton & While, 1994). The Somali male groups' observation of their school being a bad school due to lack of enforcement by teachers relates to the issue of school culture which was discussed in the introduction, whereby schools that provide effective support and control could protect pupils from smoking (Aveyard et al., 2004). As the participants in this study were from a deprived inner city area this may explain why this issue was pertinent because elements illustrating school culture, such as truancy rates, have been associated with deprivation (Department for Education, 2011).

Creating opportunity to smoke was an indication of the White British female and both of the Bangladeshi groups' perseverance to smoke after initial experimentation and also an indication of the type of barriers faced. For example, it involved overcoming barriers to accessing cigarettes such as taking cautionary measures when stealing cigarettes, seeking alternative means to access if a specific source was blocked and exercising perseverance when asking strangers for cigarettes. It also involved overcoming barriers with location to

smoke, such as finding alternative locations at school if one area was restricted and taking cautionary measures when smoking at school and in public to avoid discovery by teachers and parents.

4.3.Maintenance Stage: Negotiating smoking reality

4.3.1.Freedom

It was illustrated how freedom to smoke for participants during the maintenance stage was influenced by a range of external and internal forces, which were either accepted or rejected by participants. External forces included legal, socio-cultural and financial influences and internal forces consisted of psychological influences.

4.3.1.1.External: Legal influences

Legal influences consisting of tobacco purchase age law, graphic images on cigarette boxes and the smokefree public places legislation, impacted on all of the groups' smoking freedom, particularly in relation to their access of cigarettes and the location in which they smoked. It was mentioned in the introduction how measures have been introduced by the government to reduce smoking prevalence and to de-normalise smoking within society (Department of Health, 2004; Health Act, 2006; The Health Development Agency, 2004).

Firstly, from an effectiveness perspective, it was discovered in this study that these laws and measures were not impenetrable. For example, participants were still able to purchase cigarettes from retailers through attempts to look older, which helps account for the survey figures highlighted in the introduction, whereby 55% of 11-15 year old regular smokers in England still purchase their cigarettes from shops (The NHS Information Centre,

2009). This would lend support to tougher regulation of retailers, if their commitment to meet their legal and moral duty not to provide cigarettes to underage youth, (National Institute for Health and Clinical Excellence, 2008), is to be met. Participants from the Bangladeshi female and White British male group also described regularly flouting the smokefree legislation and participants also mentioned ignoring the graphic images on the boxes.

It was discussed in the introduction how some researchers felt that these government measures could lead to feelings of further stigmatisation and exclusion for individuals from hard-to-reach groups with a greater polarisation between smokers and non-smokers, thus perpetuating health inequalities as opposed to removing them (Haines, Poland & Johnson, 2009; Scheffels, 2009). Participants from all of the focus groups in this study expressed negative responses towards current and future anticipated government measures. Part of this arose from feelings of cynicism and distrust of government motives, particularly among the male groups, which led to 'us and them' type discussions. Hence this study indicated a polarisation between participants and the decision-makers, along with mediators of the decision-makers, such as retailers and non-smokers who complain if smoking in public, rather than with non-smokers as a whole per se.

Also rejection of these measures by participants was not predominantly due to infringement of smoking freedom (except for issue of smokefree cars) but beliefs over their ineffectiveness and resistance to change due to a sense of unfairness. Participants described how it was legally acceptable for them to purchase cigarettes one day and not the next and likewise to be able to smoke in public places one day and not the next, which led to a sense of injustice. Considering that further measures will inevitably be introduced by the government in the future, it can be argued that the effects on resistance to change need to be considered.

However, this was not applicable to all participants as some participants from all of the female groups expressed support for the initiatives, which was primarily indicated in

relation to cessation. This suggests that such measures may be more effective and receptive by those individuals who are considering cessation.

4.3.1.2.External: Socio-cultural influences

Socio-cultural influences affecting smoking freedom were experienced by all of the groups and included religious, familial, community and peer influences.

4.3.1.2.1 Religious influences

Religious influences indicated the most significant difference in experience of smoking freedom between the White British groups and the other groups. All of the groups except the White British groups discussed how religious influence affected their smoking freedom. Religion can have a considerable impact on many different aspects of life including values, belief systems, daily routines, diet and dress (UNESCO, 2011, Chowdhury, Helman & Greenhalgh, 2000; Arthur, 1999). Both the Somali and Bangladeshi participants in this study shared the religion of Islam and there were many similarities with regards to how their religion impacted on their smoking freedom. For example, both of the Somali and Bangladeshi groups spoke about observing the festival of Ramadan, which limited smoking freedom for a specific period every year (despite not all attempts being successful). However, there were also still distinctions due to the variation of level of practising amongst individuals and also gender of individuals. For example, the Somali female group discussed how dressing in traditional female religious garb was a hindrance to smoking freedom. This was not mentioned by the Bangladeshi female group as none of them wore traditional religious dress, which was the result of random selection of participants for the study as opposed to cultural differences. Also some participants, who were stricter practisers of the faith from the Somali male group, discussed how their religious beliefs informed their decision to disclose smoking

behaviour to parents. Hence it can be seen how the influence of Islam affected the smoking freedom of both of the Somali and Bangladeshi groups but there were distinctions in experience, dependent on gender and level of practising.

4.3.1.2.2. Familial influences

The experience of familial influences was similar and also contrasting between all of the focus groups. All of the groups described how familial rejection, particularly parental rejection of their smoking behaviour, restricted their freedom to smoke. There were similarities in the Somali and Bangladeshi female groups' experience with regards to exposure to negative familial attitudes towards smoking based on traditional norms opposing female youth smoking. From a cultural perspective, although geographically the countries of Somalia and Bangladesh are located in different continents as was discussed earlier, shared religion can impact on shared traditions, beliefs systems and values, which could help account for this similarity.

Familial rejection in all the groups was not just present in participants from non-smoking households, whereby anti-smoking attitudes of parents was an influence, but also from smoking households. This supports the notion that even when parents smoke themselves they do not want their own children to smoke (ACT government, 2010).

Although participants from all of the groups discussed familial rejection of their smoking behaviour, which was a barrier to smoking freedom, participants from all of the groups also described how familial awareness, familial acceptance, lack of familial retribution and lack of familial confrontation over their smoking behaviour were facilitators to their smoking freedom. In some cases familial acceptance followed on from an initial period of rejection. These familial responses facilitating smoking freedom mainly resulted from family members' own smoking behaviour. For example, through parents feeling

helpless to rebuke and discipline their children due to their own smoking behaviour. Hence it can be seen how own parental smoking status can result in greater smoking freedom for children. This freedom was also apparent through smoking parents providing an extra source of access to cigarettes for participants.

Also again the Bangladeshi and Somali female groups shared similar experiences, whereby when parental acceptance was indicated it always consisted of maternal acceptance. Due to taboos regarding female smoking, fathers were generally unaware of their smoking behaviour as participants often disclosed to their mothers or mothers discovered the behaviour. Also mothers that smoked or used to smoke showed empathy for their daughters' experience and also often undertook efforts to protect their own and daughters' reputations in the wider community. This was again due to taboos over female smoking and family shame experienced in the community over having children that smoked. Hence there appeared to be a collusive relationship to protect both the smoking participant and mother of smoking participant. This sometimes led to restrictions on where participants could smoke, such as only being allowed to smoke at home to prevent community discovery, which participants accepted. The concept of 'honour' is considered important in various South Asian cultures, such as in Bangladeshi culture, which involves preservation of self-respect and self-worth in society. This honour can be damaged by being gossiped about in the community (Centre for Social Cohesion, 2010), which could help account for this finding.

The Somali female and Bangladeshi female group along with the Somali male group also illustrated greater acceptance of familial barriers to smoking freedom than the other groups, through, for example, agreeing to cessation on parental request and having empathy with parental negative reaction to their smoking. Research has shown that, from a cultural perspective, there is an expectation for young Bangladeshis to respect their familial elders (Ballard, 1982). Similar findings have also been discovered for Somali youth whereby

traditionally Somali society is a clan society and extended family and respect for elders and authorities are generally valued over individualism (Diversity Council, 2007). Hence this could help explain this greater acceptance.

Both of the Somali groups were also considerate of parental feeling and bound by protecting the reputation of their parents in the community when it came to disclosure of smoking behaviour to parents. The parental relationship in regards to disclosure was also commented on by the Somali male group and Bangladeshi female group, whereby the Somali male group mentioned not having the correct relationship with their parents to invite disclosure, which indicated more of a relationship built on respect rather than friendship and bond. Similarly the Bangladeshi female group also mentioned how closeness of parental relationship and hence lack of retribution was an influence on disclosure.

It was apparent how the Bangladeshi male groups' experiences did not tally so much with those of the Bangladeshi female, Somali male or Somali female groups in regards to acceptance of familial barriers. This difference between Bangladeshi males and females supports findings from Markham et al's (2001) study whereby the young Bangladeshi male participants were shown to be indifferent to parental reactions and dismissive of parental ability to control smoking. This difference could be due to the fact that research has shown that smoking is a widely accepted practice among Bangladeshi men (Bush et al., 2003). Hence as a result of these traditional smoking gender norms, male Bangladeshi participants may have been less inclined to be accepting of familial attempts to limit their smoking freedom, especially given their age and that they were bordering on the verge of adulthood.

Despite participants in some groups accepting familial barriers, in the majority of cases participants from all of the focus groups rejected familial barriers to their smoking freedom. The fact that family members who were trying to limit smoking freedom were smokers or engaged in other substance use like shisha, was often discussed as a reason for

rejecting their views. For example, all the female groups pointed out the hypocrisy of smoking family members who reacted negatively to their smoking behaviour. This again highlights the impact that smoking status of family members can have on the freedom of young peoples' smoking behaviour, which in this case is to effectively rebuke the behaviour. Also the Somali and Bangladeshi female groups rejected the negative familial attitudes they had experienced towards Muslim female youth smoking, often referring to the double standard they experienced in comparison to their male smoking counterparts or elder smokers.

Finally, with regards to rejection of familial barriers, participants from all of the focus groups described how they overcame familial barriers to persevere with their smoking behaviour. All the groups apart from the White British male and Bangladeshi male groups described taking cautionary behaviour to avoid parental discovery, which relates to findings discussed above regarding Bangladeshi males being less concerned about parental response. This also relates with Bush et al's (2003) findings regarding adult Bangladeshi women hiding their smoking from family members. The White British female and Bangladeshi female group described engaging in deceit over smoking status to parents and the White British male, Bangladeshi male and Bangladeshi female group discussed refusal or being dismissive over parental requests for cessation.

4.3.1.2.3. Community influences

Barriers to smoking freedom due to community influences were discussed by all of the groups. Firstly, they consisted of negative community smoking attitudes based on age, which were encountered by the Somali female group and involved members of the community refusing to purchase cigarettes due to participants being underage. It could be argued that as smoking rates reduce in this country (The NHS Information Centre, 2009) and

measures de-normalising smoking in society are introduced, as discussed in the introduction (Department of Health, 2004; Health Act, 2006; The Health Development Agency, 2004), these attitudes may be encountered more by young smokers. However, the Somali female group also discussed how this barrier was overcome by being able to seek alternative means to accessing cigarettes, which illustrates the variety of sources of access available for young people, as was indicated in the introduction (The NHS Information Centre, 2009). Also as addiction grew, the Somali female described how there was less preference for the community being a source of cigarettes, due to not wanting to be reliant on others for cigarette access. Hence this source may be more applicable when young people are at the early maintenance stage of their smoking behaviour as opposed to later maintenance.

Negative community attitudes towards either Muslim Somali female or Bangladeshi female smoking were encountered by the Somali and Bangladeshi female group respectively. These were similar in nature to those encountered from family members and again highlight similarities in experience of barriers to smoking freedom between these two groups. The same argument discussed earlier regarding traditional smoking gender norms based on religion, as being a possible influence for the similarity, could also be applied here.

Next, risk of parental discovery of smoking behaviour via the community was discussed by all of the groups except the White British male and Bangladeshi male groups, which impacted on location of smoking. This relates with findings discussed in familial influences, which showed the White British male and Bangladeshi male group were not as concerned about parental response. The Bangladeshi female group along with both of the Somali groups were more likely to discuss how they feared repercussions of being discovered smoking and how this would have an impact on familial reputation in the community. This support findings of Markham et al. (2001) whereby Bangladeshi females feared repercussions of being caught smoking more than males. The females from the Somali and Bangladeshi

groups also described how their own reputations within the community would be jeopardised. It was discussed earlier how the concept of family honour is important within Bangladeshi culture. This honour is also often associated with female virtue (Kabeer, 1988) and the majority of Bangladeshi female participants in this study highlighted being conscious of this. The protection of family honour and saving face is also important within Somali culture (Diversity Council, 2007) and both of the Somali groups indicated how being caught smoking by the community would jeopardise this. Both Somali groups also described the elaborate network of community informants who efficiently relayed smoking behaviour back to parents, which relates back to the close clan structure of Somali communities discussed earlier.

Risk of community discovery of smoking behaviour per se and not involving reporting back to parents was mentioned by the Somali female and Bangladeshi male group. For the Somali female group this was because of parental instruction to not be discovered by the community due to preservation of reputation in the community, which was discussed earlier in familial influences. For the Bangladeshi male group it was not to be judged negatively by the community when smoking past the mosque. Hence although Bangladeshi males may not have feared parental reaction as much, there was still concern regarding community reaction when religion was involved. Finally, negative attitudes of teachers towards smoking behaviour were mentioned by the White British male and Somali female groups, which again impacted on location of smoking.

Despite the presence of these community barriers, participants from all the affected groups displayed perseverance to continue with their smoking behaviour and rejected these barriers to their smoking freedom. Markham et al. (2001) had discovered in their study that Bangladeshi females rarely smoked in public and if they did it was in localities outside of their local area, but in this study, as with the other focus groups, they did smoke in local areas

but just took cautionary measures not to be discovered. The only example of participants being receptive towards community barriers was by Deeqa from the Somali female group, who agreed with her teacher when she advised her to stop smoking. It can be seen there was a greater acceptance of familial rather than community barriers. It could be argued that generally greater closeness of relationships between family members and participants rather than community members and participants could be a responsible for this.

Although not as prevalent as community barriers, community influences could also be facilitators to smoking freedom. This was through being a source of cigarettes as discussed earlier and also through teachers smoking. Anjali from the Bangladeshi female group described how her teachers' smoking outside the college with the students made her feel more comfortable about smoking outside college. This relates to findings from other research discussed in the introduction (Poulsen et al., 2002; Charlton & While, 1994) and some of the repercussions of smokefree public places legislation, which supports the need for educational establishments to consider staff smoking policy in light of smokefree legislation.

4.3.1.2.4. Peer influences

Peer barriers to smoking freedom were only discussed by the Somali female and Bangladeshi female group, which consisted of both smoking and non-smoking peers rejecting their smoking behaviour. Both groups described non-smoking peers disapproving of their smoking, mainly due to the negative effects of smoking. However, the Bangladeshi female group also highlighted encountering hypocritical attitudes from young Bangladeshi male smokers, due to beliefs in traditional gender smoking norms. In both cases friendships and potential relationships were impacted. Hence it can be seen how there was still a significant non-smoking force featuring in the social lives of young Somali and Bangladeshi female smokers, which was exerting pressure for cessation. It could be argued that the females

reported experiencing these barriers and not the males because as discussed in the introduction there is greater prevalence of smoking amongst males from these groups, hence there was greater chance of them being exposed to non-smoking peers. Also again the issue of traditional smoking gender norms influenced smoking freedom for the Bangladeshi female group, similar to with familial and community influences.

The response to this pressure for cessation varied between participants. The Bangladeshi female group completely rejected the hypocritical opinions of young Bangladeshi male peers that smoked. However, there was mixed opinion towards the attitudes of non-smoking peers, with some receptive to their opinions and others not. This appeared related to the participants' own current views about their smoking behaviour (i.e. those with current negative attitudes towards own smoking behaviour being more receptive to negative attitudes of non-smoking peers), which was also reflected by the Somali female group. It was discussed in the introduction how studies have found that when young smokers quit smoking they often establish new non-smoking friends (McVea et al., 2009). Hence the peer group reflected participants' own stance on smoking, which could relate to why the participants who were more dissatisfied with their smoking in this study were more receptive to non-smoking peers' negative attitudes.

In addition to peer influences being barriers they were also facilitators to smoking freedom, predominantly through providing a source of access to cigarettes, which was mentioned by all of the groups. This supports the notion of peers providing opportunity to smoke both in the initiation and maintenance stage (Nichter et al., 1997; Lloyd & Lucas, 1999; Moffat & Johnson, 2001). Participants from the Bangladeshi and Somali female group also discussed how smoking peers of both genders generally accepted their smoking and that non-smoking peers gradually learnt to accept it, which in turn allowed them greater freedom to smoke.

4.3.1.3.External: Financial influences

All of the groups expressed difficulty in accessing cigarettes due to being short of money. This could be explained by the fact that the study was conducted in a deprived inner-city area. However, at the same time participants from all the groups described how they were able to overcome this barrier by, for example, sourcing cheaper cigarettes, borrowing money from others, smoking roll-ups instead and seeking alternative means to access. This lends support to the multi-tiered approach the government is taking to tackle smoking rates in the UK discussed in the introduction (Department of Health, 2004). For example, as opposed to just increasing cigarette prices in isolation, it is acknowledged wider issues also need to be addressed.

4.3.1.4.Internal: Psychological influences

Psychological barriers were expressed by all of the groups. Firstly, it was discovered how participants from all the groups apart from the White British female group mentioned having beliefs that it was disrespectful to smoke in front of parents. This was also extended to close and extended family members and elders in the community for both of the Bangladeshi and Somali groups. This relates with findings discussed earlier as to how there is a cultural expectation for young Bangladeshis and Somalis to respect their familial elders (Ballard, 1982; Diversity Council, 2007). Although Bangladeshi males in this study had shown greater disregard for and less experience of cultural restrictions than female Bangladeshis for the majority of times, in this case they accepted the cultural restriction and did not smoke in front of Bangladeshi elders. These findings also support other research conducted with young adolescent and young adult Bangladeshi males and females (Markham et al., 2001; Bush et al

2003). The Bangladeshi female group described exceptions in this study, which included having a peer-like relationship with the family member.

Secondly, psychological barriers involved feeling negative affect, such as worry, fear and upset, which resulted from the experience of socio-cultural barriers. This negative affect was mentioned by all of the groups, which indicates that participants from all the groups had the shared experience of being negatively affected by socio-cultural barriers. The experience of shame for the Bangladeshi female participants supports findings from Bush et al.'s study (2003) study with adult Bangladeshi women, where smoking was associated with stigma and shame. This similarity in experience highlights how experiences of Bangladeshi women from different generations can be similar. Also the Somali female group reported experiencing negative affect from concealing smoking behaviour from parents, which could relate with the issues discussed earlier regarding respect for family members within Somali culture.

4.3.2. Control

Next, participants highlighted the theme of control of their smoking behaviour during the maintenance stage, through loss of control and regaining control.

4.3.2.1.Loss of control

Loss of control over smoking behaviour was indicated by all of the groups through the process of physiological and psychological addiction to smoking. It was seen how a combination of biopsychosocial factors, such as enjoying the physiological effects of smoking and being around smokers, led to the process of getting addicted, which were discussed earlier with motivation for sustained smoking. Research has shown how the

positively physiological reinforcing effects, which were discussed earlier in the initiation stage, can occur very quickly and are the bases for nicotine dependence (Benowitz, 1999).

The prompt to realisation of addiction was also discussed by all the groups, which included feeling a need to smoke and not being able to quit, which are classic signs of nicotine addiction (DiFranza et al., 2011; Benowitz, 1999). Negative response to being addicted was discussed by all of the groups, except the Somali male and White British female groups, and included feeling dismay, regret and shock, which has been supported by findings from other studies (Moffat & Johnson, 2001; Johnson et al., 2004; Lucas & Lloyd, 1999). So similar to the experimentation period, it can be seen how the process of smoking involved unanticipated consequences for participants during the maintenance period. The process of being addicted was also discussed by all of the groups, which involved experiencing physiological and psychological signs of addiction, including the experience of withdrawal symptoms and behavioural routines, which have been associated with smoking addiction (United States [US] Department of Health and Human Services, 1988).

4.3.2.2.Regaining control

Regaining control involved the process of smoking cessation. Barriers and facilitators to smoking cessation were expressed by all of the groups.

4.3.2.2.1 Facilitators to abstinence/cessation

Drive for cessation

Facilitators firstly consisted of drive for past and current cessation attempts, which were both internal and external in nature. External drives for past cessation attempts were expressed by the Somali female and Bangladeshi female group and involved familial forces, for example, prevention of second-hand smoke to younger family members was mentioned

by the Bangladeshi female group and parental request for cessation by the Somali female group. Both these indicate how the family unit can be a motivating force for young Bangladeshi and Somali females, which could be related to the issues discussed earlier in familial influences on smoking freedom, whereby consideration and acceptance of familial forces was indicated. External drive for current cessation included the smokefree legislation for the Bangladeshi female group and peer request and religious beliefs for the Somali female group. Inclusion of smokefree legislation relates with the discussion earlier in legal influences about the legislation aiding with cessation. Request for peer cessation relates with earlier discussion in peer influences on smoking freedom, whereby Somali females demonstrated greater acceptance of non-smoking peers' negative attitude towards their smoking when they were considering quitting. Discussion of religious motive by the Somali female groups was also present with past attempts at abstinence. Both sets of the Bangladeshi and Somali groups described attempting to quit for Ramadan in the past, which supports findings by White, Bush, Kai, Bhopal and Rankin (2006) for adult Bangladeshi males and females. This indicates how Ramadan can be a motivation for both the younger and elder generation, although successful abstinence is not guaranteed for both parties. Again this highlights how religion can influence the smoking experience of young Somali and Bangladeshis.

Internal drives for past and current attempts consisting of health reasons, dependency on cigarettes, negative effects on physical appearance/hygiene, negative attitudes towards smoking, lack of emotional fulfilment and financial reasons, were stated by the Bangladeshi female, Somali female and White British male groups. All these internal drives reflected findings from previous research with the general population (DeLorme et al., 2003; Markham et al., 2001). The Somali female group also discussed reluctance to be negative role model for

younger people, which illustrates awareness amongst young people of the impact their smoking has on younger individuals.

Drives for future cessation was expressed by all of the groups except the White British female and mainly involved specific life events and milestones, such as having children and getting married, which relates to findings from other research (Moffat and Johnson, 2001; Balch et al., 2004).

Intentions and self-efficacy for cessation

Intentions to quit currently or in the future were expressed by participants from all of the groups. The Theory of Planned Behaviour (Ajzen, 1991) indicates how intentions to change are linked with behaviour change. Research has supported an association (Yzer et al 2001; Plotnikoff & Higginbotham 1998; Sheeran & Orbell, 1998), although it is recognised that intentions do not necessarily translate into behaviour change. Self-efficacy to quit in the future was expressed by the Bangladeshi female and Somali female groups, which resulted from witnessing others' quit attempts, experience of previous quit attempt and belief in ease of cessation. With regards to witnessing others' attempts, this supports Social Cognitive Theory and the idea of self-efficacy being affected by vicarious learning, i.e. learning via others' behaviour (Bandura, 1986). Gaining self-efficacy due to experience of previous quit attempts supports the finding that repeated attempts at cessation are often needed before smokers quit successfully (US Department of Health and Human Services, 2010).

Method of cessation/abstinence

All of the groups discussed methods they had used for past cessation attempts and/or intended to use for future cessation attempts. Past and future methods firstly concerned getting support from others. For example, the Somali female group mentioned getting support

from family members, which supports findings from a national survey of young people getting assistance from family or friends (The NHS Information Centre, 2009). Only one participant from the Bangladeshi female group mentioned accessing NHS services in the past through a counsellor, which echoes findings for adult Bangladeshi males and females whereby White, Bush, Kai, Bhopal and Rankin (2006) found that few participants had sought advice from health services. It also reflects findings for young people in the general population, where very few (2%) access the NHS (The NHS Information Centre, 2009). The White British female group commented on preferring to quit in a group in the future with others similar to themselves and not wanting to see a health professional, which has implications for possible future services.

With regards to approach to quitting, participants from the White British male, Somali male and Bangladeshi female group discussed quitting 'cold turkey' in the past, with the White British male and Bangladeshi female group also discussing cutting down. This was a method the Bangladeshi female group commented they would use again. Research conducted in Australia with 15 year old smokers found that cutting down was the preferred method (Gillespie et al., 1995). The Bangladeshi female group also mentioned wanting to use hypnosis and shisha as cessation methods. A survey conducted in Tower Hamlets, UK found that among Bangladeshi residents aged 16 and over (Ipsis MORI Social Research Institute, 2009) 2 % smoked shisha of whom 6% were from the youngest age range. Its popularity with Bangladeshi young people and the possibility of it being used as a substitute for smoking has implications for smoking cessation health promotion with this population.

Behavioural coping strategies were mentioned by all of the groups, except the White British female group, and consisted of avoiding smokers and cigarettes, and using distraction techniques to avoid thinking about smoking. Avoidance of smokers had repercussions for existing peer groups as social norms regarding smoking were attempting to be changed. Ayan

from the Somali female group even discussed the possibility of changing her peer group if peers were unsupportive, which supports findings by McVea et al. (2009) of young people changing peer groups when becoming non-smokers.

With regards to aids to quitting, the Bangladesh female and Somali female group discussed the use of sweets and normal gum and all the groups mentioned the use of Nicotine Replacement Therapy (NRT). Findings for the use of NRT among Bangladeshi youth in this study contradict those found in research with Bangladeshi adults, whereby few were found to use cessation aids like NRT (White et al., 2006). However, the overall findings support findings from a national survey conducted with the general population, which found the use of NRT was the second most popular approach used by school age pupils (The NHS Information Centre, 2009).

All the groups except the White British female and Somali male groups expressed the importance and sometimes exclusive importance of willpower for future quit attempts, which supports findings from a study conducted with adult Bangladeshi males and females by White, Bush, Kai, Bhopal and Rankin (2006), whereby willpower was the most common approach to quitting.

Finally, methods for abstaining during Ramadan were discussed by both of the Somali groups and the Bangladeshi female group, which included psychological techniques such as the use of positive thoughts, praying and willpower and behavioural methods like topping up with cigarettes prior to fasting.

4.3.2.2.2 Barriers to cessation/abstinence

Barriers to past, current and future cessation attempts were discussed by all of the groups, which comprised of relapse triggers, quit obstacles, lack of drive, lack of self-efficacy, lack of readiness, lack of intentions and cultural barriers.

Relapse triggers firstly included temptation by others including peers, family members and strangers, which were expressed by all of the female groups and the Somali male group. This highlights that as with initiation, smoking social norms can impact on cessation. The level of exposure to smoking were discussed by the focus groups in the normalisation themes of the initiation and maintenance stages, and it can be seen now how this exposure can become a barrier with cessation. Coping with stressful situations was discussed by the White British female, Bangladeshi female and Somali male groups, which supports findings with the adult general population (Wiltshire et al., 2003). Adolescence has infamously been described as a period of 'storm and stress' (Hall, 1904) with storm and stress being more likely during adolescence than at other ages (Arnett, 1999). Also using smoking as a coping mechanism can be compounded by the effects of nicotine withdrawal, which can be perceived as 'stress-like' symptoms (Hughes, 1992). Next, alcohol consumption was described by the Bangladeshi male group, which has been shown in findings for the adult general population (Shiffman, 1982). Finally, withdrawal symptoms were mentioned by all the groups, except the White British female group, which studies have shown can impact on adolescent cessation (Prokhorov et al., 2001). Relapse triggers consisting of being tempted by others, everyday stresses, and withdrawal symptoms for the Bangladeshi participants in this study, coincided with findings for adult Bangladeshi participants (White et al., 2006).

With regards to quit obstacles in past cessation attempts, these were also discussed by all the groups. Firstly, negative experience with quitting aids including NRT, was mentioned by all of the groups. Negative experience of NRT had important repercussions on future quit attempts, with some participants reluctant to use the products again. Difficulty in breaking old smoking routines was described by the Somali male group, which indicates how powerful the psychological aspect of smoking addiction, which was discussed earlier, can be. Finally,

temptation by media smoking influences was discussed by the Somali female group, which supports research suggesting that media influences can affect cessation (Wagner et al., 2011).

With regards to lack of drive for current cessation, this was indicated by participants from all of the female groups and the Bangladeshi male group. This firstly involved lack of concern over effects of smoking, which stemmed from incorrect health beliefs regarding the negative effects of smoking and belief in negative effects regarding physical appearance occurring longer-term, which were mentioned by the Somali and White British female groups. Hence from a Health Belief Model perspective (Rosenstock, 1966), it could be argued this lack of drive was indicated by low perceived susceptibility to negative effects of smoking, which has implications for health promotion messages regarding adolescent cessation. Positive attitudes towards smoking behaviour were discussed by the Somali and Bangladeshi female group, which were usually in reflection of religious and familial influences dictating otherwise. Lack of drive was also present for the Bangladeshi female group due to smoking assisting with coping with stress and anxiety. Research has shown that any positive outcomes of smoking perceived by young people, which in this case involve smoking aiding with anxiety and stress, can override any negative beliefs regarding health consequences (Samet & Yoon, 2001), which could also help account for this lack of drive for cessation. Finally, both of the Bangladeshi groups mentioned deriving emotional pleasure from smoking, which research has found to be the commonest barrier to cessation amongst adults (UW Centre for Tobacco Research and Intervention, 2005).

Lack of self-efficacy was discussed by all the groups, except the White British female group, in regards to current and future attempts. The Health Belief Model dictates how perceived efficacy can impact on health behaviour change (Rosenstock et al., 1988). Participants in the study described having desire to quit but perceived difficulty in quitting. Reasons included length of smoking behaviour, which was specified by both of the Somali

groups, and the influence of other smokers, which was mentioned by the Somali female, Bangladeshi male and White British male group and sometimes resulted due to experience of past cessation attempts. This illustrates the concerns young people can face regarding cessation, which has implications for cessation services and also illustrates the importance of considering the effect of previous cessation attempts on future cessation attempts by young people.

Lack of readiness for current cessation was stated by both the Somali groups and the Bangladeshi female group, which from a Transtheoretical Model perspective (Prochaska & DiClemente, 1983), indicates that the participants were still in the pre-contemplation stage. This was included by not having feelings to stop and not being mentally prepared for quitting. Lack of intentions for future cessation attempts were demonstrated by the White British female group due to long-term perceptions of not getting bored of smoking behaviour.

With regards to cultural barriers, the Somali male group discussed how perceived cultural differences between Somali and the White British population resulted in a perception of Somalis being less concerned about their health, which in turn impacted on efforts undertaken for cessation. This included having a greater fatalistic approach to health, which can have implications for health promotion with the Somali population.

Finally, barriers to abstinence were expressed by both of the Somali groups and both of the Bangladeshi groups, in reference to abstaining from smoking during Ramadan. These included cravings to smoke, temptation by other smokers and difficulties in breaking daily smoking routines, which participants from the Bangladeshi male group also stated thwarted attempts to sustain cessation post Ramadan. These barriers are similar to barriers for complete cessation attempts and have implications for health promotion campaigns during Ramadan.

4.3.3.Quality of life

All of the groups discussed how smoking enhanced and deprived their quality of life during the maintenance stage.

4.3.3.1. Enhanced quality of life

Enhanced quality of life was indicated through lack of drive for cessation (which was discussed in the control section), drive to smoke and positive effects of smoking.

It was seen how drive to smoke involved using smoking for social functioning, as a coping mechanism and gaining emotional fulfilment from smoking. This was similar to motivation for sustained smoking in the initiation stage. Social functioning was stated by the White British female, Bangladeshi female and Somali male groups, which supports findings from Markham et al. (2001) regarding young Bangladeshi females, and again indicates the importance of social factors in the process of smoking for young people. Smoking being a coping mechanism for emotional stress was discussed by all of the groups, which supports findings for young people in the general population (Angus Reid Group, 1997; Moffat & Johnson, 2001) and also Markham et al's (2001) research with young Bangladeshi males and females. It was discussed in the introduction how individuals from low socioeconomic status, as the participants in this study were, report higher smoking rates and one of the potential reasons identified was that smoking is used to cope with life stressors arising from social and economic deprivation (Copeland, 2003; Taylor, Langdon & Campion 2005). Also individuals low in personal resources such as social support, were identified as using smoking as a coping mechanism for stress (Wills & Shiffman, 1985). This relates with what, for example, the Somali female group reported in regards to viewing smoking as a best friend and comforter, particularly in the absence of others to provide it. The role of nicotine withdrawal

symptoms mimicking stress and hence being relieved by smoking, as was discussed earlier, could also be a contributory factor, as was acknowledged by the Bangladeshi female group. Smoking being a coping mechanism for boredom was mentioned by the Bangladeshi male group, which supports findings for adolescents in the general population (Stone & Kristeller, 1992; Hayes & Plowfield, 2007; Moffat & Johnson, 2001) and findings from Markham et al's (2001) study regarding young Bangladeshi males. Emotional fulfilment from smoking was described by all the groups and involved enjoying and liking smoking, which is indicative of the physiological and psychological addiction to smoking, which was discussed earlier. Finally, the Bangladeshi male and Somali female groups also discussed positive effects of smoking via the perception of smoking aiding with digestion.

4.3.3.2. Deprived quality of life

Deprived quality of life was indicated through drive for cessation (which was discussed earlier in the control theme), negative effects of smoking and negative perception of own smoking behaviour. Firstly, negative effects of smoking were expressed by all of the groups and included negative effects on physical health, physical appearance and personal hygiene and finances. With regards to negative effects on physical health, it was discussed in the introduction how respiratory problems such as coughing, wheezing and phlegm are more apparent in young smokers (US Department of Health and Human Services, 2004), how asthma symptoms can be exacerbated in young smokers (US Department of Health and Human Services, 2004; British Medical Association, 2002; Gillard et al., 2006) and how young smokers are generally less fit than their non-smoking peers (Marti, Abelin, Minder & Vader, 1988; Klausen, Andersen & Nandrup, 1983), all of which were evidenced in this study along with impaired sense of smell and having a bad throat. Also the risk of longer-term conditions, such as cancer were acknowledged, which supports findings of young people

being aware of negative health effects of smoking (The NHS Information Centre, 2009). It was discussed earlier how these negative effects on health, along with negative effects on physical appearance, hygiene and finances could impact on drive for cessation.

It was also discovered how negative perception of own smoking behaviour was expressed by all the groups and resulted from the negative effects just discussed, along with time costs as mentioned by the Bangladeshi female group and the influence on young peoples' smoking as mentioned by the Bangladeshi male group (which relates with the drive for cessation expressed earlier by the Somali female group, again highlighting adolescents from these groups being conscious of the effect of their smoking on others). This led to negative image of, attitudes and feelings towards smoking by all the groups, for example, the Bangladeshi male group describing smoking as a curse and the Bangladeshi female group describing sadness at loss of identity without smoking. The Bangladeshi female and Somali female groups also outlined how their initial positive perceptions of smoking changed during the maintenance stage due to not gaining emotional fulfilment anymore and initial drives for smoking not being realised. Hence similar to the initiation stage, this indicates how the smoking process involved experiencing unanticipated consequences. Participants also tended to reflect back negatively on their smoking behaviour. For example, the White British female group spoke about now feeling like a hypocrite due to original anti-smoking views. Both of the Bangladeshi and the White British male groups reflected negatively on initial drive for smoking describing it as dumb and stupid, and all the groups expressed regret over starting smoking. Having regret supports comments from other researchers (Slovic, 2001) and again indicates how the original perceptions of the smoking journey envisaged at initiation do not necessarily tally with reality.

4.3.4.Normalisation

Firstly, with regards to normalisation, all of the groups indicated smoking being the norm, which was highlighted through lack of drive for cessation, drive to smoke, facilitators to smoking freedom and reclaiming smoking freedom, which have already been discussed. This was also illustrated through beliefs in smoking as rites of passage, exposure to others' smoking, acceptance of others' smoking and belief in equilibrium between smokers and non-smokers. With regards to beliefs in smoking as rites of passage, it was demonstrated how all of the groups except the Bangladeshi male group spoke about smoking being a normal and natural part of growing up, which could also help account for the acceptance of smoking peers' smoking behaviour and encouragement of non-smoking peer's interest to smoke by some participants in the Bangladeshi female group. It was illustrated in the pre-initiation and initiation stage how participants from all the focus groups described being exposed to smoking through family members, peers and general society and this was continued into the maintenance stage with participants from all of the groups describing exposure to high prevalence of smoking. Hence it could be argued that these social norms around smoking could have impacted on these beliefs in smok

ing being a rites of passage. Also it was discovered how sometimes this high prevalence of smoking was over-estimated, with the Bangladeshi male group over-estimating national smoking rates. This supports research which found individuals aged 16 and over in England over-estimated the prevalence of smoking in the UK, with misperception being greater among the young and old whereby 83% of those aged 16-24 years over-estimated smoking prevalence (for example, 60% thought national smoking rates were at least 50% when they were actually 25% at the time) (West, 2007). Also all groups aside from the Bangladeshi male group expressed belief in fundamental equilibrium between smokers and

non-smokers, indicating that they did not view smokers in any better or worse light than non-smokers.

All of the groups also indicated smoking being deviant from the norm, which was highlighted through drive and intentions for cessation, barriers to smoking freedom and relinquishing freedom to smoke, which have already been discussed. This was also illustrated through beliefs in smoking not being a rites of passage, exposure to non-smokers, rejection of others' smoking and positive perception of non-smokers due to non-smoking behaviour. With regards to rites of passage, it was discovered how in addition to participants from the female groups indicating beliefs in smoking as rites of passage, some participants from these groups also expressed the reverse. The Somali female group were also the only group who indicated low prevalence of smoking in the household and amongst Somali females as a whole, which reflected the cultural norm. They also expressed exposure to a high frequency of successful quitters. Experience of successful quitters was mentioned by all the groups, except the White British female and Somali male group. It was seen how this experience dictated own quit experience for the White British male, Somali female and Bangladeshi female groups with regards to beliefs on effective cessation methods, methods used for own cessation behaviour and self-efficacy regarding cessation. Findings from other research also illustrate this, for example, Moffat and Johnson (2001) discovered that cessation strategies used by the female participants in their study were sometimes based on observing others who have quit successfully. The Somali female and Bangladeshi female group also rejected others' smoking by discouraging non-smoking peers to smoke and encouraging cessation amongst peers and family members, which also highlighted their own dissatisfaction with their smoking behaviour in the maintenance stage. The Somali male, White British male and Bangladeshi female group also expressed positive opinion of non-smokers, which highlights the contrast

between the initiation and maintenance stage whereby non-smokers, specifically peers, were seen in a disparaging light at the time of initiation.

4.4.Summary

Overall it can be seen how experience of the smoking process from the pre-initiation stage to the maintenance stage was similar in many ways between the groups regardless of ethnic background, shaped by a variety of psychological, physiological and social processes. However, there were also differences, which mainly resulted as a result of religious and cultural norms, which were experienced by both of the Bangladeshi and Somali groups and predominantly featured in the maintenance stage. It was illustrated how these norms were considered to be restrictive of personal liberty and were challenged, particularly by the female participants in this study. This presented a rather paradoxical situation whereby although limitations were being placed on the choice to smoke, at the same time individuals were being liberated from engaging in an addiction in which one has impaired choice over behaviour. This was realised by some participants at a later stage when attempts at cessation and regret over smoking behaviour were revealed.

The change in these cultural norms and the rejection of traditional norms indicates the fluid nature of culture. Hence it is recognised that the socio-cultural processes described in this study are not stagnant but open to flux and change. This was supported by the fact that findings by Markham et al. (2001) with young Bangladeshi female youth, did not always correspond with findings in this study.

It is important to reiterate that the purpose of this study was not to stereotype populations. However, the importance of conducting studies with hard-to-reach ethnic minority groups is recognised. It can be argued that by being aware of distinctions in the

smoking experience of different groups and gaining further insight into the smoking experience of groups which are not as represented in mainstream research, a more integrative and inclusive picture of the smoking experience which is relevant to all groups, can be gained.

4.5. Recommendations and implications

Findings from this research could be used by professionals who work with youth generally and also within the area of youth smoking.

From a pre-initiation perspective the findings could be used to inform health promotion campaigns regarding the importance of smokefree homes because it was discovered how influential, exposure to familial smoking, was during the pre-initiation stage. Also it is important that these campaigns are executed in a way that effectively raises awareness in all communities, such as the Bangladeshi and Somali community, which means acknowledging potential barriers, for example, cultural norms around the acceptance of male smoking.

From an initiation perspective, these findings can assist with smoking prevention work done in school, for example in Personal, Social, Health and Education (PSHE) lessons. Messages that could be emphasised include that smoking is not the norm in the general population, the addictive nature of smoking (even with just experimentation), negative experiences of experimentation and deprivation in quality of life (even when younger, such as impact on fitness levels). Peer-led initiatives are prevalent in schools today and these messages could be conveyed by young smokers who have first-hand experience of the issues, especially with regards to the message of feeling regret at having started smoking and the negative repercussions in having to overcome ongoing barriers to smoking freedom, such as

feelings of fear over discovery, guilt and shame. Also as opposed to an individualistic approach being taken, the wider context of smoking also needs to be explored, such as the wider socio-cultural influences. Hence it can be argued that a broader life skills approach needs to be taken which, for example, equips young people with the confidence not to conform to social pressure to smoke, or to deal with familial conflict at home, which would be useful not just in regards to prevention of smoking uptake but also general social functioning.

Also there are implications for the wider school culture with regards to having effectively enforced anti-smoking school policies and measures to ensure separate staff smoking quarters away from students. Also as part of a school culture that provides support, there could be implications for assisting students with cessation as well as prevention of smoking. This could be done through linking up with local Stop Smoking Services.

Other agencies working with children and also Stop Smoking Services could gain further insight into the issues faced by young people when trying to stop smoking, for example, with the social impact stopping smoking can have on young people, in terms of avoiding smoking peers or having to change peer groups. Also information on barriers, methods and drive for cessation could help inform health promotion campaigns for youth smoking cessation as well as aid in provision of cessation services. Stop Smoking Services working with Bangladeshi and Somali youth could also gain insight into specific socio-cultural influences that could impact on their smoking behaviour, to help assist with cessation attempts and also assist with promotional campaigns, such as those based on Ramadan.

The findings could also have implications from a more political perspective with regards to the legislative measures introduced to address smoking. For example, by having greater enforcement of the tobacco purchase law among retailers and gauging youth response to current measures.

Overall it is recommended a multi-layered approach needs to be taken to address youth smoking, which addresses the wide range of influences that impact upon it.

4.6. Further research

Potential for further research involves conducting qualitative research with non-smoking Somali and Bangladeshi adolescents to explore what processes prevent them from taking up smoking. Also exploring parental attitudes towards youth smoking amongst the Somali and Bangladeshi population would be insightful, as participants appeared to indicate difference in response according to gender of child. In addition, exploring the process of being a smoking parent of a smoking child would be useful as it was seen how this impacted on parental response to discovery of child's smoking behaviour, which influenced smoking freedom for the young participants.

4.7.Limitations and challenges

Given the small sample of this study it is recognised that the results are not generalisable to the wider White British, Somali and Bangladeshi adolescent population. However, attempts to make the study rigorous were made, firstly by reporting the methodology used in gathering data in a careful and structured way and addressing validity by cross checking the results back with the participants, to ensure they were reflective of their experiences.

It is still appreciated though that participants selected from the different ethnic groups in this study were not representative of all young people from these groups, especially as they also comprised of pre-existing friendship groups. This for example, was represented by the

fact that none of the Bangladeshi females in this study wore religious garb when other adolescent Bangladeshi females in society do. Hence other Bangladeshi females' experience of, for example, smoking in public, may have been different to the participants in this study.

There were also a number of challenges encountered in conducting this study, which were primarily concerned with the participant recruitment phase. One issue which had not been anticipated was that some youth clubs had all-inclusive ethos and so the gatekeepers did not feel comfortable telling their members that only certain individuals from specific ethnic groups could take part. However, fortunately they were happy for the researcher to talk directly to their club members.

The process of participant recruitment for the study was particularly difficult with the Somali and Bangladeshi female participants. Although it had been anticipated from the outset that this would be a challenge, it was not realised how difficult the process would be. This was mainly in part due to locating youth worker contacts that worked with Somali and Bangladeshi females of the required age group (as many agencies worked with younger and older females) and who were receptive to the research. Some contacts when called directly said that none of their club members would confess to smoking and were reluctant to discuss it with their members. This was despite the rationale for the research being emphasised. Others would not return contact. Literature into effective participant recruitment was reviewed. Many of the recommendations outlined were already being incorporated, for example, scheduling regular call backs with contacts and remaining polite and respectful (Warren, Pegues & Meyer, 2002) and being flexible with times and location (Patel, Doku & Tennakoon, 2003). Ultimately the method which proved most effective was liaising with the young persons' worker at the local Stop Smoking Service. The researcher was able to accompany the young persons' worker to local youth events in the area which meant direct relationships with youth worker contacts could be built. As a result they were more receptive

to the research and allowed the researcher to discuss the research with their members. This was a lot more effective than cold calling. Once this stage was reached and the researcher was able to meet the young people in person, they were keen to participate (once confidentiality could be assured). Overall the difficulties in recruiting hard-to-reach participants should not be considered a deterrent to conducting research with these groups but demonstrates the even greater importance of carrying out the research and to explore different recruitment methods.

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SECTION C

PROFESSIONAL PRACTICE

GENERIC PROFESSIONAL COMPETENCE

Working as a Health Psychologist in Training at a Stop Smoking Service

GENERIC PROFESSIONAL COMPETENCE: WORKING AS A HEALTH PSYCHOLOGIST IN TRAINING AT A STOP SMOKING SERVICE

1. Implement and maintain systems for legal, ethical and professional standards in applied psychology

While working at the Primary Care Trust (PCT) I worked in accordance with The British Psychological Society's (BPS) Code of Ethics and Conduct (2006). This involved following the principles of 'respect', 'competence', 'integrity' and 'responsibility', which will now be discussed in turn. During the latter stages of my training the Health Professions Council published the Standards of Proficiency for Practitioner Psychologists (2010), which were also adhered to.

1.1.Respect

In regards to the principle of 'respect', the standard of 'general respect' coincided with National Health Service (NHS) policy, which I was also required to abide by. For example, the standard outlined respecting individual, cultural and role differences such as those involving disability, ethnicity, gender and race , which tallied with NHS legislation, such as the Race Relations Amendment (2000); Equality (2006); Sex (1975) and Disability (2005) Discrimination Acts. This was implemented by, for example, making use of interpreting services for clients who had difficulties with English or ensuring disability access when running training programs. When first joining the Trust, I attended a three day introductory course, which outlined the various policies and procedures I was required to follow and I kept myself continually updated with them.

The standard of 'privacy and confidentiality' in relation to the principle of 'respect' was also particularly pertinent to my work. With my clinical work (which consisted of providing smoking cessation support to clients), I always outlined the boundaries of confidentiality by telling clients the information they disclosed in sessions would remain confidential unless they posed harm to themselves or others. There were a number of occasions when I did have to involve external parties, for example, when a client disclosed suicidal intentions. However, I always discussed my actions with my Manager prior to taking any action as recommended by the BPS Code of Ethics and Conduct (2006), which in this case was to inform the client's General Practitioner (GP) of my concerns. In the eventuality of the GP being non-contactable, contact with the local Mental Health Crisis Team would have been made. Privacy and confidentiality regarding data storage was also of key importance. The PCT had a range of policies regarding data handling and storage to meet with the Data Protection Act (1998), such as the Records Management Policy (2008) and Security Policy (2008), which I implemented. They involved carrying out more small scale activities as well as larger organisational ones, for example, changing computer passwords monthly, keeping all paper data locked away, having encrypted password protection on laptops, data sticks and computer files, and not sending client information over email unless it was via a secured 'nhs.net' account.

The standard of 'informed consent' was adhered to in a number of ways. For example, before storing a client's information on the central database their consent was obtained by asking them to read the agreement, which stated, "I understand the reasons for collecting this personal information and agree to the information that I have provided being stored and used for evaluation purposes. I agree to be contacted again for follow up," and then to sign their name. Also I made sure that those individuals I was supervising also implemented such procedures. For example, I provided clinical supervision for the PCT's Health Trainers, part

of which involved observing their clinical sessions. I always ensured they had obtained their clients' consent prior to me being present in the sessions.

1.2. Competence

In regards to the principle of 'competence', the standards of 'recognising limits of own competence' and 'ethical decision-making', featured considerably in my practice. I recognised the boundaries of my role as a Health Psychologist in Training at the Stop Smoking Service and made sure I did not work outside of them. Although I outlined my role to clients in the first session there would be times when they would expect additional support that I was not qualified to provide, such as guidance on their marital problems or help dealing with low mood. I had to deal with such situations in a tactful and sensitive way without alienating the clients. I would empathise with their situation but inform them that I did not have the relevant expertise to assist with such matters, and stress that there was help available and that they should see their GP to get referred to the appropriate service. At other times I would provide them with the service details myself, such as a list of self-referral counselling services.

In regards to the standard of 'ethical decision-making,' I always considered the ethical repercussions of my practice at work. If I had any concerns about my duties I always raised them with my supervisor. For example, there was a major retrospective data collection project our service had to undertake which had been sanctioned by the Senior Management Team (SMT). This involved calling clients who had originally been seen by our stop smoking advisors based at GP practices and pharmacies up to a few years earlier, to identify whether they had become successful quitters. I was concerned about whether these clients had given consent to being called up by our service, which I raised with my Manager. Fortunately my

Manager also had the same concerns, which she raised with the SMT and a protocol was developed which did not jeopardise the clients' consent.

1.3. Integrity

With the principle of integrity, the standards of 'honesty and accuracy' and 'maintaining personal boundaries' were particularly applied in my practice. For example, with regards to honesty and accuracy, I informed my clients that my job title was a Health Psychologist in Training. This was particularly important when I conducted my clinical sessions in the local hospital as there was a tendency for clients to automatically assume I had a medical background. I was aware that the general public may not be aware of what constitutes a Health Psychologist and how the role differs from other psychology professions such as a Clinical or Counselling Psychologist so I gave a brief description of my role to outline the distinction. I was mindful of the fact that the term 'psychologist' might automatically be equated with the mental health field, which I clarified.

The standard of maintaining personal boundaries was also pertinent to the clinical work I carried out. I ensured I kept a professional relationship with clients at all times. There were times clients asked inappropriate personal questions or expressed wishes to conduct personal relationship. These situations were challenging to deal with as I wanted to maintain and not jeopardise my professional relationship with the clients. I initially sought advice from my Manager and colleagues on how to manage such situations and eventually became confident at dealing with them. I also reflected on my own conduct in supervision sessions with my Manager, to ensure I had maintained professionalism at all times.

1.4. Responsibility

Finally, with the principle of 'responsibility', the standards applying to conducting research were met by completing the ethics procedure for City University. I also contacted the Centre of Research Ethical Campaign (COREC) about gaining ethical consent for my research and they informed me this was not required as my research did not involve NHS clients and did not meet the criteria for undertaking the process. However, I still reviewed their ethics form to make sure my research addressed any relevant criteria.

1.5. Reflection

The target driven culture of the NHS was a complex issue to deal with in regards to ethical practice, as I found it sometimes conflicted with the BPS Code of Ethics and Conduct (2006). For example, with the incident discussed earlier about the retrospective data collection project, when our service had to call clients who had seen our stop smoking advisors based at GP practices and pharmacies I originally felt the SMT had just been interested in how our service could meet its targets without considering the human cost enough. For example, by not considering whether clients had given their consent to being called up by our service, the effects on clients being called up to a few years after they sought stop smoking assistance and other potential repercussions, such as the effect of the phone call on family members if clients had passed away. I was able to discuss these issues with my Manager and my team who fortunately had the same concerns and we were able to address them. However, it was disheartening that they had to be raised by our team without the SMT having envisaged such problems from the outset. I was always mindful of keeping patient care as the priority. However, I also saw the positive aspects of having targets when patient care was improved, for example, ensuring our service was accessible to specialist client

groups, such as those with mental health problems, pregnant women and from different ethnic backgrounds.

I sometimes found when developing in this competency that I had to put a lot of my personal opinions aside and discipline my natural impulses in order to maintain professionalism. For example, with the example cited above regarding recognising the limits of my own competence, when clients wanted support in areas outside of smoking cessation, my natural instinct was to help them by allowing them to talk about external issues. However, I realised my input could potentially be counterproductive and that the best way to assist them was to refer them on. Overall developing in this area to date has been a challenging yet rewarding learning curve, which has provided me with great insight into my personal character.

2. Contribute to the continuing development of self as professional applied psychologist

Over the two years working at the PCT I noticed that my practice became governed by health psychological principles on a more instinctual level whereas prior to that there was a more conscious effort involved. I feel part of the reason for this is that I continually worked on developing myself as a professional applied psychologist throughout my time at the PCT. One of the first ways in which I did this was to have monthly supervision sessions with my Line Manager who was also a chartered Health Psychologist. These sessions allowed me to reflect on the psychological basis of my work. Fortunately, I was given the creative freedom by my Manager to incorporate health psychology principles into my work and to develop service provision based on them. For example, when developing a campaign encouraging Muslim people to quit smoking for a religious festival, I was encouraged to draw upon health promotion principles grounded in health psychology theory to inform my work. The

supervision sessions in combination with my practice reflection log also allowed me to identify gaps in my learning and identify areas for development, which were then incorporated into my work plan. For example, I discussed how I did not feel very confident in delivering oral presentations due to lack of experience and so my supervisor identified more opportunities for me to conduct them to help build my confidence.

I was aware of the importance of keeping up-to-date with all of the latest developments in the health psychology field to ensure I was applying the most recent evidence-based information in my practice. One way I did this was to regularly read the latest health psychology journals. When starting at the service, my Line Manager suggested the idea of having a monthly health psychology meeting with her, myself and two other health psychology trainees working in the service. When deciding on the content of these meetings I suggested having discussions on the latest research being conducted in the area, which was agreed upon. This was not just limited to research in the smoking cessation field but all areas which were felt to be beneficial in developing as an all-rounded applied psychologist. The monthly group health psychology meetings also presented another opportunity to reflect on the health psychological basis of our work. For example, we had to present regular client case studies and discuss how health psychology theory had guided the intervention we provided. Sharing ideas in these meetings assisted greatly with my professional development as an applied psychologist, as I gained greater insight into my practice and was offered alternative ways of working with my clients.

I am a member of the Division of Health Psychology (DHP) and attended the annual DHP conference. Having these contacts with the wider health psychology field was again beneficial in my continual professional development, as it provided me with opportunity to develop skills outside of the smoking cessation world. For example, it gave me the opportunity to explore other aspects of the Health Psychology field I am interested in. I

presented poster presentations at two of the conferences I attended, which was my first experience of presenting at a conference. One of the presentations was based on my MSc research on living with coronary heart disease and the other on the development of a smoking cessation training programme for health professionals. I was also able to utilise the opportunities that were presented from my Line Manager being a board member of the DHP, such as writing a consultation response on behalf of the DHP on government legislation to reduce the minimum tobacco purchase age from 18 to 16 years.

Another way I helped to develop myself as an applied psychologist was to promote my discipline within the department and the wider working environment. As health psychology is a relatively new field compared to other psychological fields, there was a great lack of awareness regarding its content and purpose. One way I helped promote it was to present the work I developed based on its principles at non-psychological meetings and conferences, such as the National Tobacco Cessation conference. I also engaged in discussions with my colleagues highlighting the health psychological basis of my work whenever applicable. I found being in situations where I had to promote and at times defend my profession was good for my personal development.

2.1.Reflection

I felt having a Line Manager who was a Health Psychologist was very beneficial when it came to my continual professional development as an applied health psychologist, as for example, I did not have to justify the importance of attending health psychological conferences or incorporating health psychological principles into my work. However, at the same time the service priorities were in the field of smoking cessation and so I had to make a concerted effort to try and develop myself in areas beyond this field. Fortunately many of the

duties I undertake at work are varied (for example, ranging from clinical work to health promotion) and the majority of skills and knowledge I have acquired are transferable to other areas. I have found it difficult, given the relatively new status of health psychology as a discipline compared to other fields of psychology, to try to establish a definitive career path which is rather daunting and unsettling at times. This is compounded by the fact many health professionals are unaware of health psychology and its role, which would often come as a shock as I was relatively sheltered from such views within my department. However, at the same time I realise the opportunities that are presented with such a situation and that it is an exciting time to be involved, where I can play my part in helping to develop the field.

3. Provide psychological advice and guidance to others

I provided psychological advice and guidance in a variety of ways during my two years of practice. Firstly, I provided stop smoking support to individuals (on a one-to-one basis or group setting), which consisted of pharmacological therapy and behavioural support. It was the behavioural support that drew upon health psychological theory and principles, namely the Health Action Process Approach (Shwarzer, 1992), Stages of Change model (Prochaska & DiClemente, 1983) and Motivational Interviewing (Miller & Rollnick, 1991). The intervention involved seeing clients for a five week period and during that time a range of health psychology techniques were employed to promote behaviour change including, assessing motivation, addressing ambivalence to change, increasing confidence, goal-setting and action-planning. Providing guidance to clients using these techniques was predominantly well-received as a number of them felt that the psychological aspects maintaining smoking behaviour were the most challenging aspects to address when attempting to stop smoking and maintain abstinence.

I also offered psychological advice and guidance by providing health psychology clinical supervision to two of the four Health Trainers employed by the PCT. The supervision consisted of monthly hour long sessions on a one-to-one basis, which involved discussion on clinical practice, presentation of client case studies, observation of clinical practice, etc. The basis of their clinical intervention (providing support with stopping smoking, increasing physical activity, healthy eating) is health psychological in nature so I would, for example, review health behaviour change models with them. They were not trained psychologists and in fact did not have any formal qualifications (because one of the main premises of the Health Trainer programme was to recruit individuals that the community in which they worked could identify with) and so I tried to relay psychological theory to them in a jargon free manner to aid with comprehension.

The other way in which I provided psychological advice and guidance was to train health professionals in providing one-to-one stop smoking support consisting of pharmacological and behavioural support discussed earlier. It was sometimes challenging teaching the behavioural support aspects, for example, the essence of Motivational Interviewing to the health professionals because they often came from a medical background. There was the tendency for them to be rather prescriptive in their approach and found it difficult adjusting to a new way of interacting with clients where the relationship was more collaborative. However, the methods employed on the training day, such as a presentation on facilitating behaviour change and the use of role-plays, assisted in helping them to appreciate alternative ways of working.

I was also providing psychological advice and guidance to colleagues consistently on an ad-hoc basis. For example, assisting them with the development of promotional literature and campaigns based on health psychology principles, helping them review literature appropriately through the use of systematic reviews, literature reviews and critical appraisal

skills etc, and providing guidance on all aspects of stage one and stage two in health psychology to the numerous psychology student volunteers and assistant psychologists working at the service.

3.1.Reflection

I realised when providing psychological advice and guidance to a range of groups how you have to tailor your approach accordingly. I found it most challenging with the Health Trainers because of their lack of academic background. The experience made me realise how indoctrinated health psychological terminology is within me and how perhaps because I use it in everyday life, I take it for granted. It was a good experience for me to sit back and reflect on psychological terms from another viewpoint.

Through providing psychological advice and guidance to a range of different groups I realised and appreciated just how multi-faceted and varied such guidance can be and how it can relate to many different areas of work. Over the years I have been training, I feel providing guidance from a psychological standpoint is becoming more implicit. It was a daunting experience providing such guidance at first due to my anxiety I might say the wrong thing or that I would not have enough knowledge to help others. However, my confidence has increased over time and I have realised that one of the main ways to develop in this field is through experience, which is what I am hoping to continuously develop.

4. Provide feedback to clients

I provided feedback to a range of different clients in a number of different ways. Firstly, when providing stop smoking support to clients I communicated feedback on their

progress, which was done both verbally and non-verbally (Dixon & O'Hara, 2009). For example, abstinence was praised and rewarded, through the use of verbal praise, the presentation of a certificate, and with smiles and open gestures. However, I was aware that some people do not respond favourably or feel uncomfortable with praise so I always adapted myself with each client. If a client had relapsed and genuinely wished to avoid doing so again I would usually empathise with them before helping to identify solutions. When I thought clients were not committing to the programme I drew them back to the boundaries of treatment agreed in the first session. As I worked with such a wide range of clients, such as those from varying demographic backgrounds, with mental health problems, with difficulties in speaking English, etc., there was not one set way of communicating feedback. I was aware communicating feedback to one client in one way would not necessarily be perceived the same way by another client (Stewart & Logan, 1998; Hargie et al, 2004) and so adapted my approach. Overall though, I felt providing effective feedback resulted from having an accurate representation of the situation and this involved having good listening skills (Spitzberg, 1994). Therefore I would engage in active listening, summarising and paraphrasing etc (Dixon & O'Hara, 2009) and then respond accordingly.

I also provided feedback as part of my role in supporting stop smoking advisors once they had been trained. If any of them had low activity rates (which meant they were not meeting their allocated target of seeing clients) or if complaints were made about their conduct or the service offered, it was my duty to provide feedback to them and try to troubleshoot any problems. It was difficult dealing with these situations because I did not want to offend or upset anyone, which Dixon & O'Hara (2009) cite is a common fear when providing honest feedback. However, I appreciated the necessity of the task. Having tact and diplomacy were key (Goleman, 1996), so for example, I tried to establish both sides of the story first and avoided using language which was accusatory in nature. Arriving at a

resolution often involved a lot of 'thinking on the spot' and required good problem-solving ability (Goleman, 1996). Dealing with these situations became easier with experience, as my self-confidence in being able to handle them appropriately, grew. Fortunately not all experiences of providing feedback to the advisors were of providing negative feedback. I also helped organise an awards ceremony to recognise the achievements of our advisors over the year. It was important that positive feedback was also given by acknowledging the good work carried out by the advisors.

Providing health psychology supervision to the Health Trainers also involved giving feedback. For example, when observing their clinical sessions I provided them with constructive feedback on their therapeutic style, clinical knowledge etc. When there were areas of development or improvement required I was always mindful of providing praise and encouragement for the positive aspects before outlining the points for learning (Goleman, 1996; Dixon & O'Hara, 2009). This was similar to when I provided feedback to trainees when facilitating teaching and training sessions or providing feedback to candidates after being interviewed for voluntary student placements. I communicated the positive aspects of their participation and engagement before discussing areas of improvement, why they were unsuitable etc. However, I always tried to end the feedback with words of encouragement. Consulting with colleagues to gain their opinions prior to giving feedback was also very useful, which is when effective team work also came into play.

When providing feedback to clients I was also aware of the appropriate medium to use because, for example, communicating feedback face-to-face is very different to doing it via email (Clampitt, 2005). It is for this reason I would not use certain mediums for certain feedback, for example, I would not conduct clinical interventions via email, as the language used can often be subject to very different interpretations due to the absence of supporting verbal and bodily cues (Holmes, 1994). Also the language used would be different according

to the client, for example, emails sent to senior members of staff and those I was not familiar with would be more formal than those sent to my team members.

4.1.Reflection

I found providing feedback to clients one of the more challenging duties I was required to do. This was because I felt there was a great deal of opportunity for miscommunication or error to occur on my part which could have potentially far-reaching negative consequences. This was particularly the case when clients had relapsed because I was very mindful of jeopardising the relationship when providing feedback. I found reflecting on the approach I was to undertake, with my Manager and colleagues, was very useful and again this was an area I became more confident in through experience.

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SECTION C

PROFESSIONAL PRACTICE

TEACHING AND TRAINING COMPETENCE

Level II Stop Smoking Training Programme

TEACHING AND TRAINING COMPETENCE: LEVEL II STOP SMOKING TRAINING PROGRAMME

1. Plan and design training programmes that enable students to learn about psychological knowledge, skills and practices

The remit for the training programme was provided by the Stop Smoking Service Manager, who wanted to redesign the one-day level II training stop smoking programme offered by the service to health professionals. Level II stop smoking support consists of providing one-to-one behavioural support for a period of five weeks in combination with the use of pharmacological aids. Its use within the National Health Service (NHS) has been recommended by the Thorax smoking cessation guidelines for health professionals (West, McNeill & Raw, 2000).

A needs assessment, as recommended by Hauer and Quill (2011), was conducted through a meeting with the Service Manager (refer to appendix 1). It was identified that the training programme was needed to produce level II advisors who would be active in carrying out level II support and be effective in delivering it. This was because although the existing training programme was producing a large number of trained level II advisors, their activity and success rates were not meeting service targets. Also the training programme had to be relevant for all Health Professionals being trained, with regards to their specific client groups, and be delivered at a level that all trainees could comprehend. This fits into the notion that individuals have different learning styles, which can require different teaching methods for optimal learning (Honey and Mumford, 2001). Three colleagues in addition to myself were to be responsible for delivering the training.

Next, the learning objectives were identified, as recommended by Heron (1999) (refer to appendix 1), through reference to the Health Development Agency (2003) document, 'Standard for Training in Smoking Cessation Treatments,' and discussion with the Service Manager and Service Team. The learning objectives identified, included equipping the trainees with the necessary knowledge, skills and confidence to conduct effective level II stop smoking support. This relates with Bloom's (1956) taxonomy of learning objectives, which identifies three domains of learning; the cognitive, psychomotor and affective. Overall there were two components that were addressed with regards to planning of the training; the application process and the actual training day itself. The learning objectives were explicitly outlined on the application form, because as Race and Smith (1996) state, it is important trainees are aware of the purpose of the training session. Also on the day of the training, trainees were to be given the opportunity to outline their expectations of the day at the start of the session, which would then be revisited at the end of the session to ensure these expectations had been met.

There were two major changes made to the application process. Firstly, it was used as a means of screening potential trainees. A literature review was conducted into effective training and the findings were incorporated into questions on the application form to screen suitable applicants (refer to appendix 2 for application form). This involved applicants being asked questions relating to, for example, their practical capacity to provide level II support, level of managerial support (Ford et al., 1992) and control over workload (Huczynski & Lewis, 1980), and also their interpersonal skills, such as communication skills (Bobak, 2007). There was also a section on the form which had to be completed by the applicant's Manager as verification for the applicant's responses. The second major change was to conduct some of the knowledge-based training prior to the training day, by incorporating a pre-learning component into the application process. This consisted of applicants having to read a level II

advisor handbook and successfully complete a quiz on the contents (refer to appendix 3 for quiz). This was done to free up the actual training for more skills-based training, as lack of skills have been identified as a barrier for health professionals in providing cessation support (Kottke et al., 1994; Taylor et al., 2003) and also trainee feedback from previous training sessions expressed a desire for greater skills-based activities.

With regards to the training day a variety of training methods were employed. This was because as Honey and Mumford (2001) state, individuals have different learning styles, such as the activist who prefers to learn by activity and the reflector who prefers to be given information and allowed time to think about it. So, for example, skills based activities included the use of role-plays, which promoted learning through activity, and also group scenario exercises, which gave trainees time to contemplate and discuss responses in small groups before sharing their responses with all the groups. These methods were developed from the existing training program, along with feedback received from past trainees on popular methods, and discussions with other local Stop Smoking Services on effective methods used in their training programmes (refer to appendix 4 for a programme of the training day).

A number of visual aids including PowerPoint presentations, flipcharts and handouts were to be used and when developing content, audience engagement and comprehension were key influencing factors (Race & Brown, 2005). For example, with my presentation on facilitating behaviour change, which involved discussion on health psychological theory, attempts were made not to make the language too psychological to prevent alienating the audience who were not psychologically versed. Also the design of the slides was kept clear with a good font size to ensure visibility and practice sessions in delivering the material were carried out to ensure I was familiar with my material and presented within the designated time limit (refer to appendix 5 for copies of the slides).

Finally, provisions for booking the training room, IT equipment, catering and organising the administration (such as developing sign in sheets and name badges) were also made, as recommended by Race and Smith (1996).

1.1.Reflection on planning and designing a training programme

I found selecting the best teaching methods to effectively meet the trainees' needs and learning objectives to be a complex process, particularly with regards to building trainee skills and confidence. I felt this was mainly because this was my first experience of developing a training programme. However, I found having the opportunity to discuss and share ideas with another local Stop Smoking Service to be extremely useful. This is because it helped me step away from the confines of how things are usually done in the service and provided me with a more innovative approach to meeting the training objectives, for example, using the scenario group exercises to develop level II support skills.

It was advantageous that as a result of employing a variety of teaching methods to meet the learning objectives, this also assisted in addressing some of the trainee needs, for example, catering to the range of learning styles. However, meeting some of the other trainee needs was more challenging because they were impacted by the practical constraints of the programme (such as length of time of the training programme) or conflicted with the needs of other trainees. For example, when trying to equip trainees with the necessary skills to work with their specific client group, there was not enough time in the training day to cover all the skills required for each client group. Therefore I had to try to balance the needs of all the trainees as much as I could by providing the audience with enough generic basic skills that they could adapt and build upon when working with their individual client groups.

2. Deliver such training programmes

As there were a variety of preparation duties to carry out prior to the trainees' arrival these were distributed amongst all the members of the training team. I assisted with duties that included setting up the seating, preparing the training materials and conducting final checks with catering. Consideration of the room layout was very important (Pont, 2003). The training was delivered in two rooms, one was used for the majority of the teaching and the second was needed to accommodate the group activities and catering. When arranging the seating in the main teaching room, the chairs were arranged in a semi-circular formation and tables were not used. This was to provide a more informal and less academic atmosphere to the training, to encourage audience participation.

I ensured all my training materials including prompts were at hand, that the clock was visible from my presenting spot so I could keep an eye on the time and that I had water nearby. Arrangements were also made with the training team beforehand that the lead presenter and facilitator would answer the audience questions but that the other team members could contribute if an important point had been neglected.

When the trainees arrived the main focus was to ensure they were equipped and prepared for the day ahead and made to feel welcomed, as recommended by Race and Smith (1996). After signing in, name badges (which also indicated the groups they would be working in for the practical sessions) and agendas of the day were distributed, and refreshments were also offered.

My allocated training duties in the session included delivering a brief PowerPoint presentation on facilitating behaviour change and the use of carbon monoxide machines, facilitating an interactive session on 'what makes a good level II advisor', facilitating a practical session on using a Carbon Monoxide machine and facilitating small group activities

on client scenarios, question and answer sessions and role-plays. When presenting for the first time I remembered to introduce myself and was conscious of my body language and voice projection (Race & Brown, 2005), for example, I tried to maintain eye contact with the audience and keep an open demeanour. When facilitating I was aware of giving clear instructions, checking for understanding and providing positive feedback and praise to the audience to encourage them to actively participate in all the sessions (Pont, 2003).

During the training day there were slight setbacks, which required flexible working by the training team to deal with. For example, there were some sessions that overran and so quick decisions had to be made about which sessions to cut back on.

2.1.Reflection on delivering a training programme

As this was the first time the revised training programme was being delivered it was quite a stressful experience because I had concerns over how the different components of the training parts would fare. I always find presenting quite an anxious experience and doing deep breathing exercises to help calm my nerves was very helpful. I found that my voice suffered over the whole day, and although drinking water helped, I realised I should have carried out some vocal exercises prior to the start of the training.

Having three other members of the team training alongside was very helpful as the day was very physically demanding whereby I was either presenting, organising materials, facilitating interactive sessions, while at the same time being constantly alert the whole time to questioning from the trainees. Also having other team members present was useful if challenging questions arose from the trainees as everyone could contribute accordingly. When I did get some free time I found it useful to reflect on my conduct in the training so far,

for example, to reflect on how I dealt with the audience when they gave incorrect responses, so I could make decisions on any changes I felt I needed to make.

One thing I found challenging was to constantly remain aware of my body language to keep the audience engaged while at the same time trying to remember my training material. This is something that I hope will become more automatic as I develop my experience of presenting. Also having the role of presenter and facilitator and changing between the two throughout the day was also a difficult experience. When I was presenting I felt that I had a clearer direction in my head as to how the session would progress because I was dictating a great part of the session with the content of my presentation. However, when it came to facilitating the group exercises, I felt I had less control over the direction because the audience input would play a significant part in directing the course of the session. Being confident in my training material helped me feel less apprehensive with this reduced sense of control.

Dealing with slight setbacks on the day, such as some of the sessions overrunning, was not so difficult. As this was the first time the training was being delivered there had been an expectation this might occur so contingency plans had been put in order. This really demonstrated to me how organisation and pre-planning are key to the smooth running of a training programme.

3. Plan and implement assessment procedures for such training programmes

To assess whether the audience had met the learning objectives of the programme it was decided to use subjective and also more objective measures to get a more holistic picture of their learning. Kirkpatrick and Kirkpatrick (2006) state there are four levels of learning which can be assessed; i) reaction, ii) learning, iii) behaviour and iv) results. With regards to

ii) learning, the aim is to measure the extent of students' learning from the training programme. This was done through the development of an evaluation form, which all trainees completed at the end of the training programme (refer to appendix 6). This asked trainees' to rate their knowledge, skills and confidence in providing level II support on a Likert scale. The majority of the trainees stated that they felt 'very confident' or 'confident' in delivering level II stop smoking support to clients (refer to appendix 7 for results from the evaluation forms). The majority also agreed 'very much so' and 'quite a lot' that they had sufficient knowledge and skills to deliver effective level II stop smoking support. Also learning was evaluated by revisiting the learning objectives that trainees had outlined at the beginning of the session, to ensure they had been met, which they had been.

More objective measures to assess skills included monitoring the trainees' smoking cessation activity after the training programme, in regards to how many clients they see and their quit rates. This relates with the behaviour and results levels of learning outlined by Kirkpatrick and Kirkpatrick (2006). These measures will be undertaken six months after the training day by reviewing monitoring forms which all level II advisors complete when seeing clients. The trainees also had to complete an action plan, which includes mandatory actions, such as supporting four clients per quarter. So monitoring whether the trainees stick to these action plans every quarter will also provide an indication of whether they met the learning objectives.

3.1.Reflection on planning and implementing assessment procedures for a training programme

I found developing assessment procedures for the training programme quite an automatic and natural process. Using my own experience of attending training programmes

helped in giving me an insight into the types of questions that needed to be asked. Also having a fair amount of previous experience in developing such procedures also helped.

In addition to identifying how well the learning objectives were met, the assessment procedures were also advantageous because when you are delivering the training you have your own personal ideas about how much the audience have learnt from their participation and it is good to have these confirmed or refuted with the standardised procedures. It was rewarding to discover that the trainees felt they had the necessary, skills and knowledge to deliver level II support, although whether this is reflected in their actual practice remains to be evaluated.

4. Evaluate such training programmes

Kirkpatrick and Kirkpatrick (2006) also recommend evaluating students' reaction to the training programme. The evaluation form which was developed broke down all sections of the programme, and invited trainees to indicate the usefulness of each on a Likert scale. By having an indication of the usefulness of each component of the training would allow the service to identify which specific areas were weaker than others and could be improved upon in the future. Responses of the trainees indicated that every part of the training was perceived as 'useful' or 'very useful'. Overall role-plays and the interactive sessions were perceived as the most useful parts of the training. There were also open-ended questions which allowed trainees to give opinions on what else they felt should be included in the programme. Comments included wanting more strategies for working with mental health clients.

Also a meeting was also held after the training day with the Service Manager and everyone involved in the training to discuss how the training session had fared, in order to

identify areas for improvement. For example, discussions were had on which parts of the programme overran and how time slots could be changed for the next training programme.

4.1.Reflection on evaluating a training programme

It was encouraging that the majority of the trainees found all parts of the training very useful or useful. With regards to comments made regarding more strategies to work with mental health groups, it had been recognised by the service that a number of our trainees were from mental health services and therefore a specific training session for mental health workers was being developed. Those trainees from mental health services who had attended the level II training programme were also to be given the opportunity to attend the specialist training.

It was beneficial having the post training evaluation meeting in addition to the evaluation forms, because background operations that the trainees were not aware of, such as the overrunning of sessions could be acknowledged and addressed for future training sessions.

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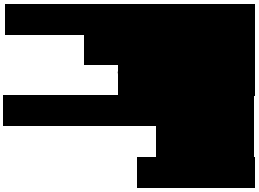
Appendices

Appendix 1

Needs Assessment and Learning Objectives

Activity	**Needs Assessment and Learning Objectives**
Meeting with the Service Manager	The Service Manager outlined that she wanted to redesign the level II training programme offered to Health Professionals because the current programme was not producing active level II advisors and those that were active had low success rates in terms of meeting quitter targets. As a result the aim of the level II training programme was to produce active and effective level II advisors. It was agreed that the training programme would continue to be offered to all Health Professionals in the locality who were in contact with smokers. As a result the training programme had to be relevant for all Health Professionals with regards to their specific client groups and be delivered at a level that all trainees could comprehend.
Consultation with Health Development Agency (2003) document, 'Standard for Training in Smoking Cessation Treatments'	The document outlined recommendations regarding the training of health professionals as advisors which were incorporated into the training programme. This included equipping trainees with the knowledge, skills and confidence to conduct level II support.
Meeting with advisors from neighbouring stop smoking service	A meeting was arranged with advisors from a neighbouring stop smoking service to discuss how they ran the training programme to see if it could help to inform our training programme. It was discovered how interactive activities were popular with trainees and it was felt some of their training methods, such as the inclusion of scenario group exercises, could be incorporated into our training programme.
Discussion with trainees at the start of the training session	Trainees were invited to state their expectations for the training day at the start of the training day. These were revisited at the end of the training session to ensure these expectations had been met.

Appendix 2



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 applicant's 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]

(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

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. Do you speak any languages in addition to English (please specify):

_____

11.Would you be able to see clients for smoking cessation support within a month of training?

Yes ☐ No ☐

12. Would you be able to provide stop smoking support to at least four clients per quarter?

Yes ☐ No ☐

13a. 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?

_____

_____

_____

13b. 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 manufacturer's 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 4 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 3

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 2007 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 [redacted]

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:

Alternatively, you can fax the quiz to us on:
[redacted]

Thank you!

Appendix 4

Level II Training in Smoking Cessation

Programme

9.30	***Tea & Coffee***
9.45	Introduction to [redacted]
10.05	Level II Advisor Pack
10.15	What Makes a Good Level II Advisor?
10.30	Facilitating Behaviour Change
10.40	CO-Monitoring
11.10	***Break***
	Session 1
11.20	Champix
11.30	NRT & Zyban – Practical Session
12.00	NRT & Zyban – Questions and Answers
12.10	Role Play
13.00	***Lunch***
	Session 2
13.40	Practical Session
14.00	Role Play
	Session 3 and 4
14.25	Practical Session
14.45	Role Play
15.10	***Break***
	Session 5
15.20	Role Play
15.45	Other Issues
15.55	Questions and Answers
16.05	What Happens Next?
16.10	Questions
16.20	Evaluation
16.30	End of Level II Training Day
16.30	PGD Training for Pharmacists
17.30	End of PGD Training

Appendix 5

Presentation Slides Handouts

SMOKEFREE

Level II Training Smoking Cessation

Monday 18th June 2007
****** PCT
Smokefree ******

1

SMOKEFREE

Aim
To become level II advisors, able to provide effective stop smoking support

Objective
To gain the right knowledge, skills and confidence to implement level II stop smoking support

1

Overview

- Introduction to Smokefree Camden
- Level II Advisor Pack
- What Makes a Good Advisor?
- Facilitating Behaviour Change
- CO-Monitoring

Break

Session 1

- Champix
- NRT & Zyban
- – Practical Session
- – Questions and Answers
- Role Play

Lunch

3

Overview (cont.)

Session 2

- Practical Session
- Role Play

Session s 3 and 4

- Practical Session
- Role Play

Tea & Coffee Break

Session 5

- Role Play
- Other Issues
- Questions and Answers
- What Happens Next?
- Questions
- Evaluation

4

SMOKEFREE

Stop Smoking Services

- Established in 1999 following the "Smoking Kills" White Paper (1998)
- Highly evidence based and one of the most cost effective interventions in the NHS
- NRT/ Zyban and Behavioural Support for at least 4 weeks is the optimum for best long-term outcomes

5

SMOKEFREE

3 Types of Service

Level 1	**Brief Intervention** Support workers, Health professionals, receptionists, sports centre staff
Level 2	**Individual Support** GPs, Practice Nurses, Pharmacists, Specialist advisors
Level 3	**Specialist Service/ Group Support** Specialist Advisors

6

Level 2: Individual Support

- Meet client weekly for 5 weeks (approx 20-30mins)
- Week 1 - Preparation
- Week 2 - Quit date
- Weeks 3-5 Support

- How effective is this? 40-50% at 4-weeks. Approx 13% cessation at 1 year

Services In ******: Level 2 Advisors

- **Provided by around 200 community-based health professionals across ******: Pharmacists, Health Trainers, Practice Nurses**
- **Due to mix of providers we have services provided days evenings and weekends, therefore we should be able to find a convenient location for all**
- **Services available in different languages to cater for our BME communities**

Smokefree Team: Specialist Support Service

Groups available across the borough (days and evenings)

1 to 1 support for complex clients

Support for families and parents-to-be
Dedicated Advisor, *** ******

Referral to the Specialist Service

Options:

1. Call while the client is there to make an appointment for them
2. Client phones FREEPHONE number **********
3. You can fax a referral form
4. Client or you can e-mail us (stopsmoking@*********nhs.uk)

Smokefree Team - Legislation

Smoke Free ****** Team
- –Partnership with ****** Council

Smoke Free Workplaces
- –SME's
- –Homeless hostels

Action around sales to minors
- –Working with schools
- –Increasing age of sale for cigarettes

Action around counterfeit tobacco

Community work - Bangladeshi, Irish and Somali

Multi-media Campaign

What Makes A Good Level II Advisor?

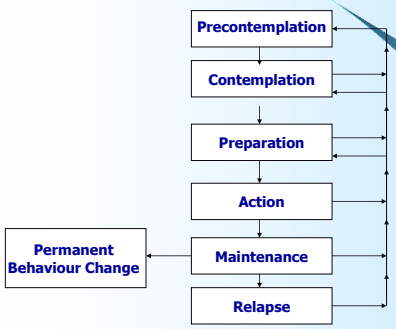
Facilitating Behaviour Change

- Approach of Level II Stop Smoking Program Based on :
  - Spirit of Motivational Interviewing
  - Stages of Change Model

Spirit of Motivational Interviewing

- Motivation to change comes from the client
- The client is responsible for choosing to change
- Relationship is characterised by a partnership
- Style is quiet and eliciting

Stages of Change Model – Prochaska & DiClemente 1983



Carbon Monoxide (CO) Machine

- Two main functions for its use:

1) Provides physiological validation of a client's quit attempt
   - 0-6 ppm non-smoker level
   - 10 ppm and above is smoker's level
   - Unexpected low CO readings due to: client not holding breath for long enough or blowing into monitor properly, client hasn't smoked for more than 12 hours, exercise will speed up the excretion of CO
   - Unexpected high readings due to exposure to high levels of CO (check for faulty boilers, certain occupations have high exposure, cross interference from other breath constituents like hydrogen resulting from lactose intolerance)
   - Recalibrate CO Machine

2) Good motivational tool for a client to stay stopped

Using the CO machine

- Explain the purpose of taking a CO reading to the client
- Technique:
  - Put machine on. Attach mouthpiece (holding the mouthpiece from the bottom)
  - Ask the client to hold their breath for 15 seconds
  - Get them to breath out slowly and deeply into the mouthpiece with lips around the mouthpiece
  - Explain the reading. Switch machine off

What Happens Next?

DEVELOP ACTION PLAN WHICH INCLUDES:

- Providing level II stop smoking support to at least 4 clients per quarter
- Seeing clients within the first month of training
- Attending next level II update training session and one session annually thereafter
- Actively promoting your service
- Informing Smokefree ****** of any changes that will impact on your ability to carry out level II stop smoking support

Appendix 6

Evaluation form - Level II Training

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

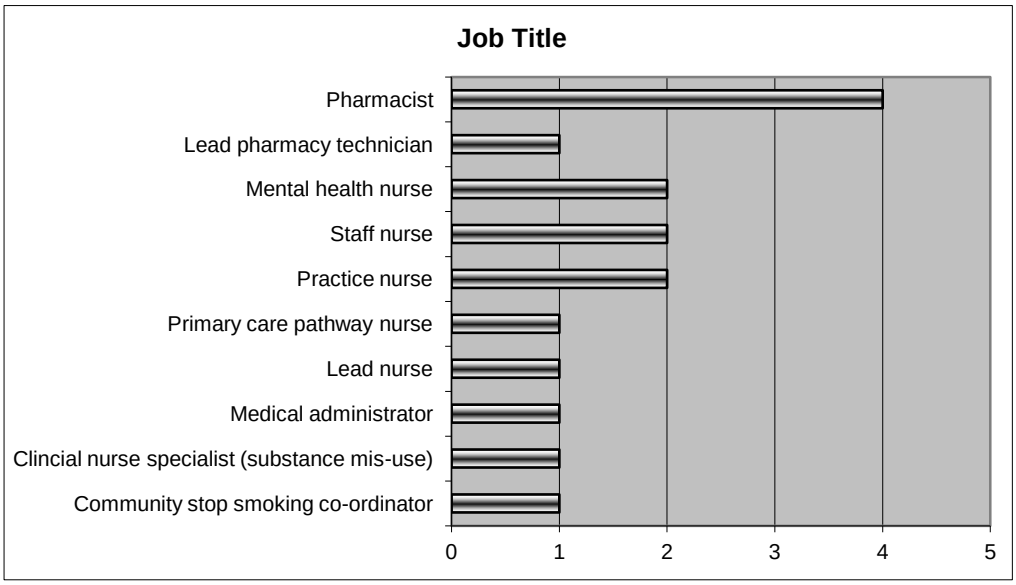
8. What further help and support do you think you will need to put what you have learnt today into practice?

9. Any other comments

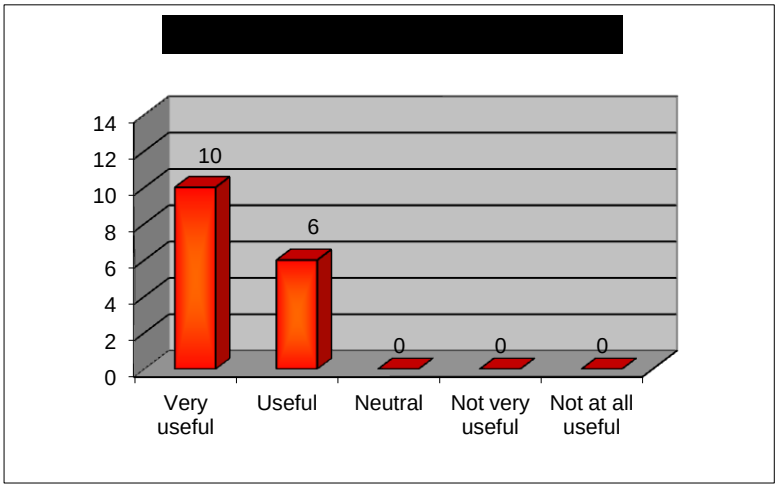
Thank You!

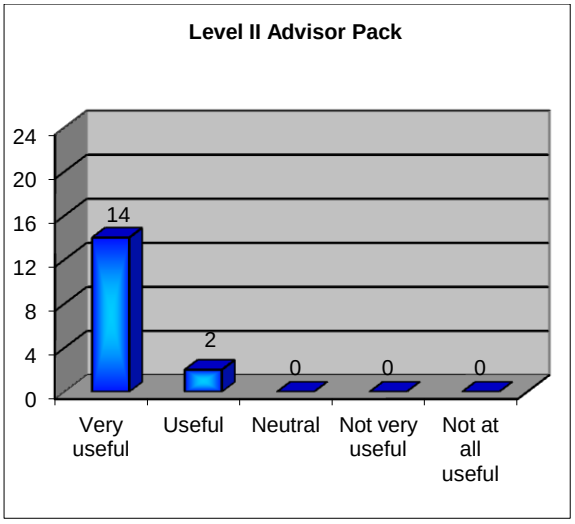
Appendix 7

Results from Evaluation Form for Level II Training



1. How useful did you find the following parts of the presentation?




Level II Advisor Pack
24
20
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14
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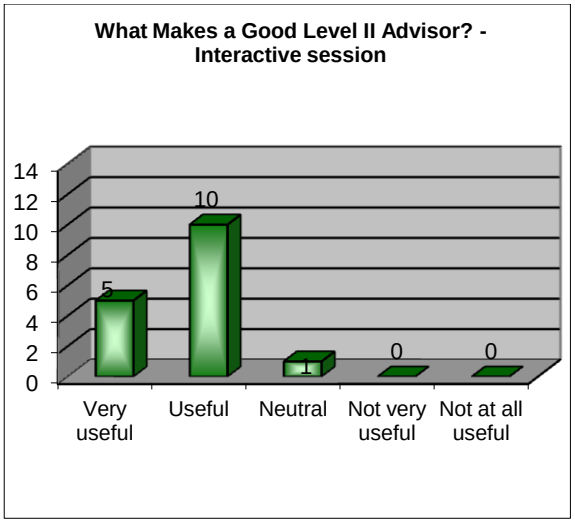
0
Very useful
Useful
Neutral
Not very useful
Not at all useful


What Makes a Good Level II Advisor? - Interactive session
14
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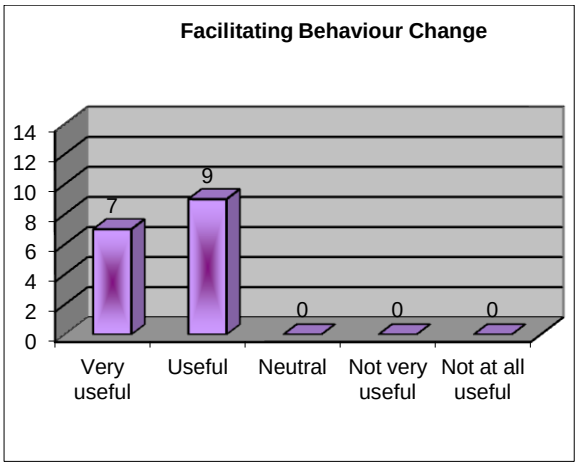
Very useful
Useful
Neutral
Not very useful
Not at all useful


Facilitating Behaviour Change
14
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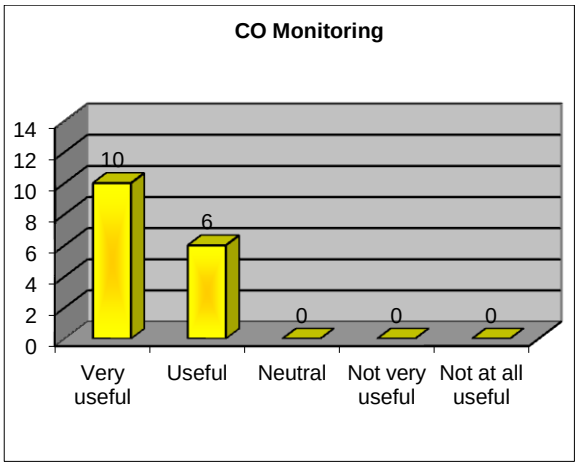
Very useful
Useful
Neutral
Not very useful
Not at all useful


CO Monitoring
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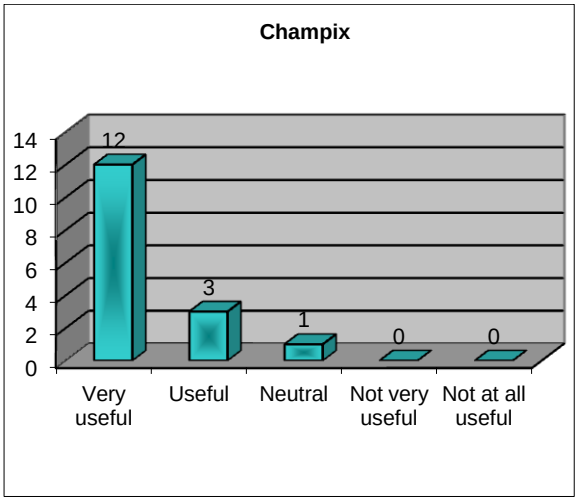
Champix
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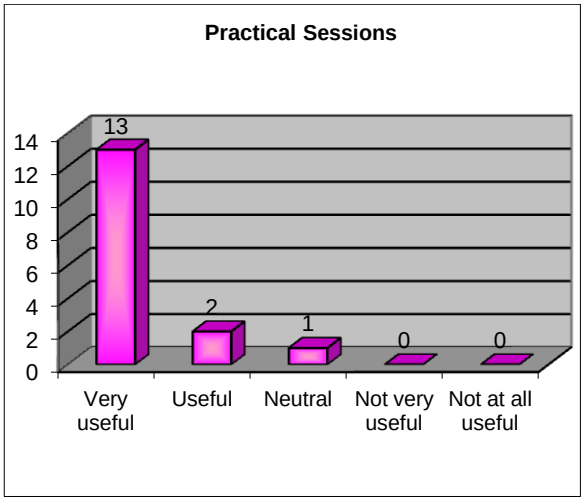
Practical Sessions
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Very useful
Useful
Neutral
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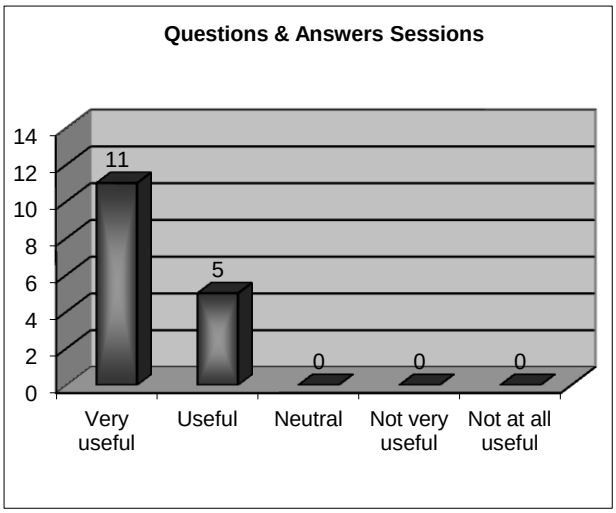

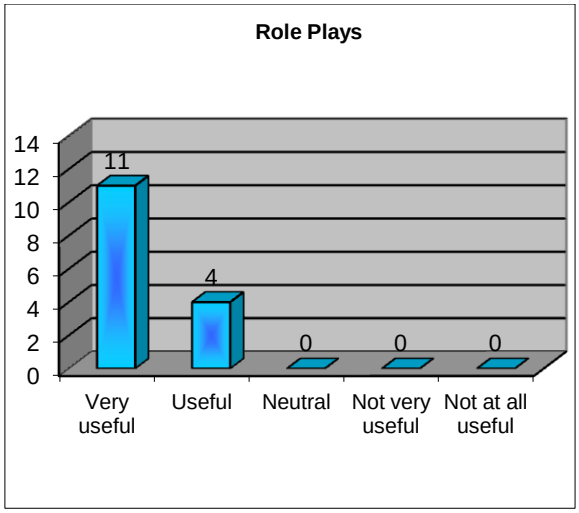

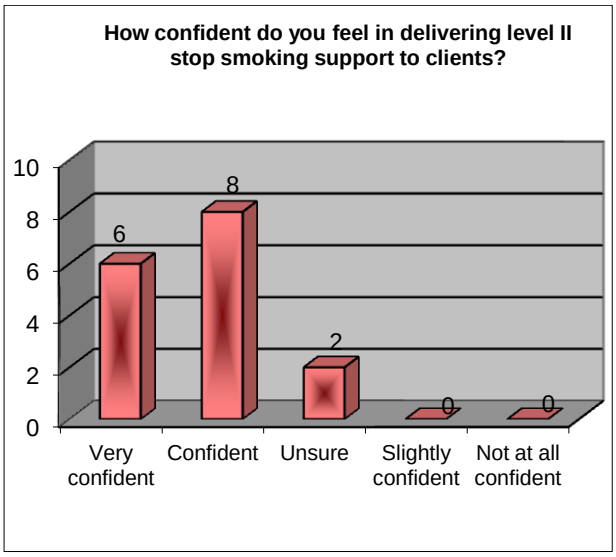

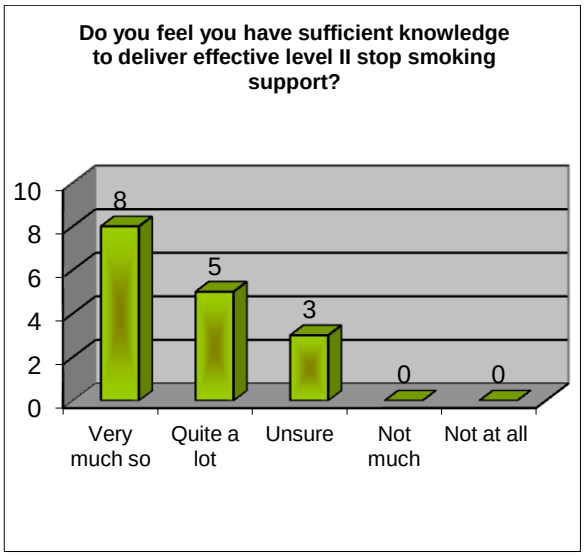

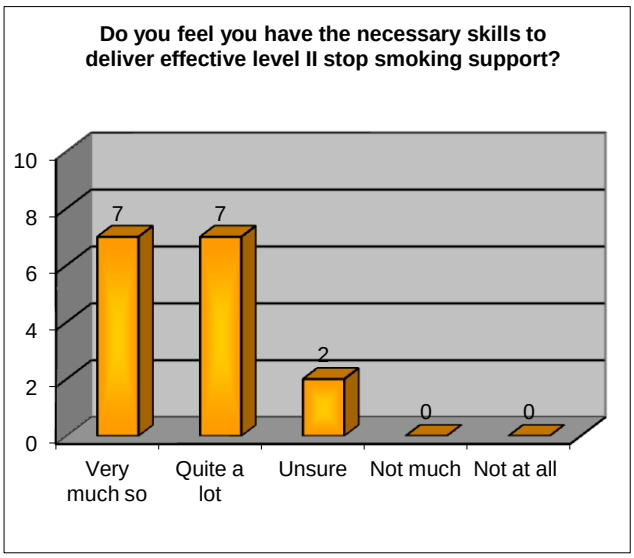

2. What were the most useful parts of the training?

- 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?

- None

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 using 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 8

Review of evaluation

Overall it could be seen that the training programme had been effective in meeting its learning objectives, which were to equip trainees with the necessary knowledge, skills and confidence to provide level II stop smoking support. This was indicated through feedback on the evaluation forms and also from trainees on the actual training day when reviewing their expectations for the day. More objective measures of reviewing trainees' activity and success rates could not be assessed until six months after the training programme which is when the trainees would have seen their first set of clients for the full five week level II programme.

Recommendations for future training programmes included reviewing time slots for each section of the programme to ensure the training session did not overrun again. Also the need to offer a more specialist training for mental health workers was also reinforced.

Appendix 9

Observation on video recording

At the start of the session I remembered to introduce myself and mentioned my role at the service and also gave the opportunity for the trainees to stop me at any point to answer questions. The first section I was delivering was 'what makes a good level II advisor?' I noticed I was gesticulating a lot with my hands which I did not realise I do at the time. I was remembering to look up and maintain eye contact with the trainees. However, I realised that I was repeating the word 'so' a lot and I think this was an indication of my nerves at the time. I need to be aware of this when delivering future sessions.

I tried to give clear instructions on how the group exercise was to work, which consisted of discussing the qualities of a good advisor. When the groups were working on the task I walked around to check that they were clear on the aim of the task and also to make sure I was available if they had any questions. I noticed however that my arms were crossed in front of me which could have been perceived as a barrier and so am mindful of keeping a more open body language in future. I kept an eye on the clock to ensure we stuck to the time allocated for the group activity.

When the groups were invited back to discuss their responses with the whole group I made use of a flip chart in order to make use of a variety of different visual aids in order to help keep the trainees engaged. When one of the trainees was asked to relay the feedback from her group she made a joke and I acknowledged the joke which I felt helped me to build rapport with the group. When the feedback was being given I was writing it onto the flipchart. However, I found it very challenging trying to write and also to actively reflect on the responses while at the same time keeping engaged with the respondent. In future sessions I think it would be more appropriate if I asked a colleague to note the responses while I

physically engaged with the respondents. I tried to covey positive feedback to the respondents by nodding my head and giving verbal encouragement.

When I was faced with a trainee giving a response we would not normally advise I empathised with her reasoning for her comment before proceeding to give the recommended course of action. This was to ensure that the respondent did not feel inhibited in participating in the other activities for fear of giving an incorrect answer.

I noticed at times that my breathing was very shallow and I think in future I need to learn to breathe more when I'm talking. I think again this was the result of nerves. I feel engaging in some breathing exercises prior to training would be beneficial for me.

Before moving onto the next part of the training session I checked with the trainees to ensure they were clear on everything that had been discussed. When moving onto the next session I realised I had been doing a fair bit of talking and realised I could be asking more questions to the trainees. Therefore when it came to discussing the Carbon Monoxide (CO) monitors, I tried to ask some questions to the trainees regarding the purpose of the monitor. When the trainees responded to my questions I tried to keep an open body language. I realised I was licking my lips quite frequently and had a dry mouth so in future I am aware of keeping myself hydrated. Although I had a bottle of water present I should have used it more.

Overall I felt that I was engaging with the audience but in future I need to be aware of how my nerves manifest and take measures to help with this, such as the use of breathing exercises. Hopefully this will be something that improves as my experience of conducting training sessions increases.

SECTION C

PROFESSIONAL PRACTICE

TEACHING AND TRAINING COMPETENCE

Stop Smoking Workshop for Young People with Challenging Behaviours

TEACHING AND TRAINING COMPETENCE: STOP SMOKING WORKSHOP FOR YOUNG PEOPLE WITH CHALLENGING BEHAVIOURS

1. Plan and design training programmes that enable students to learn about psychological knowledge, skills and practices

I was invited to run a workshop on stopping smoking by the Manager of a shared accommodation unit for youths with challenging behaviour, aged between 13-18 years. Currently the rate of regular smoking among 11-15 year olds has nearly halved since the mid 1990s, falling from 13% in 1996 to 6% in 2008. Smoking rates among older teenagers have also taken a downward turn since the start of the new millennia with smoking prevalence among 16-19 year olds in 2007 at 21% (The National Health Service [NHS] Information Centre, 2009). However, smoking rates among young people who are looked after by the local authorities are significantly higher, with 69% of 11-17 year olds in residential care smoking and 22% in foster care smoking (Office for National Statistics, 2003). The effects of smoking at a young age include addiction and immediate health risks, such as greater susceptibility to respiratory problems like coughing, wheezing and phlegm (United States [US] Department of Health and Human Services, 2004) and longer-term health risks, such as higher age-specific rates for all types of tobacco-related cancers linked primarily to earlier exposure to harmful toxins from cigarettes (World Health Organisation International Agency for Research, 2004). Hence youth smoking is an important public health issue, especially when considering that the majority of smokers start smoking during adolescence (Office for National Statistics, 2008) and tend to continue the habit into adulthood (Charlton et al., 2010).

A needs assessment, as recommended by Hauer and Quill (2011), was conducted through phone discussions with the Unit Manager (refer to appendix 1). The Manager mentioned how the unit regularly provided health events for the young people and because a significant number of young people smoked at the unit and that they had expressed an interest in learning more about smoking, she felt it would be an appropriate topic for their next workshop. She highlighted the range of ages at the unit and specified that it would need to be engaging for the whole audience and conducted at a level they could all understand. A period of one hour was specified for the workshop and I was informed it would take place just prior to the young peoples' evening meal. Numbers attending could not be guaranteed due to the unpredictable nature of the young people but it was estimated 15 individuals would be attending the event. Two members of staff from the unit were also to be present with me during the workshop for health and safety reasons.

The learning objectives of the workshop, as recommended by Heron (1999), were also established through phone discussions with the Unit Manager (refer to appendix 1). She mentioned the young people had expressed a desire to learn more about the effects of smoking and ways to quit, as a result of an earlier health awareness day at the hostel. So the learning objectives were to provide the young people with knowledge on the effects of smoking and cessation methods. I also attempted to build an audience profile (Verderber et al., 2008) to help meet the learning objectives, for example, determining with the Unit Manager whether workshop attendance was mandatory or voluntary, the number of smokers/non-smokers, etc. Ideally I would have liked to have spoken with the young people themselves but time constraints did not allow for this. However, on the day of the workshop the young people would be asked regarding their expectations from the workshop, which would be revisited at the end of the session to ensure they had been met.

To ensure that the teaching methods I employed were effective in meeting the learning objectives I consulted with a young person's stop smoking advisor, conducted a literature review into teaching methods for young people, had meetings with my supervisor and reflected on my own teaching experiences when younger.

I established the room size and room layout, which is important when planning a teaching or training session (The Council on Quality and Leadership, 2003) and I checked the availability of PowerPoint facilities with the Unit Manager. To make the session a workshop as opposed to a regular teaching session I decided to take more of an andragogical approach as opposed to a pedagogical approach, which is traditionally associated with teaching children (Knowles, 1980). The aim was to engage the audience through audience participation and to keep the session as interactive as possible.

Not only was I mindful of the difference in age range of the young people but also that individuals have different learning styles, as stated by Honey and Mumford (2001), and so I attempted to cater for different learning styles through the use of a variety of teaching methods. It was decided to start the session with a quiz on smoking, which contained questions with varying degrees of difficulty, to address different learning capabilities (refer to appendix 2). The quiz was to be completed in small groups because as Killen (2007) states, they allow more opportunity for individuals to voice their opinions. The purpose of the quiz at the start was to elicit immediate learning involvement, as recommended by Silberman (2006). The quiz was to be followed by a very brief PowerPoint presentation covering the effects of smoking, the reasons people smoke and ways to stop smoking. The presentation was to be very visual, for example, graphic descriptions of the content of a cigarette and the physical effects of smoking, and low on text. Props were also used as an additional aid, such as a tar jar and contents of a cigarette display board. A variety of visual aids and props were

used because they are recommended when teaching children with behavioural problems, whereby retaining attention can be problematic (Smith, 2009).

The training content was tailored to meet the learning objectives (Race & Smith, 1996). For example, when discussing the effects of smoking, instead of stressing the longer-term health effects (as may be done with an adult audience), other factors, such as ageing effects and financial costs, were prioritised. This is because research has shown that although young people are aware of the longer-term health effects of smoking, this knowledge does not dissuade them from smoking due to an optimistic bias (Waltenbaugh & Zagummy, 2004), and as a result it is recommended that emphasising short-term or cosmetic effects may have a greater impact (Goldberg, 2010). Group discussion was to be encouraged throughout with regular opportunities for questions. This was to maintain the interactive element of the session. Also to assist in relaying knowledge about cessation, role-plays were to be used to demonstrate withdrawal symptoms. For example, by asking the young people who had attempted to quit smoking to role-play their quit experience. Role-plays were used because research with a young people has found that students' interest in and understanding of the topic is raised and there is increased involvement on the part of the student (Poorman, 2002).

I tried to keep the language and terminology used throughout as simple as possible to ensure comprehension, for example, instead of stating 'smoking cessation methods' I stated 'ways of stopping smoking'. At the end of the session all the young people were to be provided with the handouts of the slides, as recommended by Race and Smith (1996), (refer to appendix 3), along with information on local smoking cessation services for those young people interested in quitting smoking.

I had to allow a degree of flexibility in the workshop schedule to accommodate changes in numbers attending. The final programme for the session and presentation was

presented to the Unit Manager and my own Manager for feedback before being finalised (refer to appendix 4 for final programme).

1.1. Reflection on planning and designing a training programme

I was nervous about carrying out the workshop. This was partly as I was not used to talking to such a young audience about smoking cessation and also because the children had a history of challenging behaviours, so I was unsure how they would respond to an external speaker. This was exacerbated by the fact that the workshop was to take place during their 'free-time' in the evening just prior to their evening meal. The fact that the young people had requested this workshop themselves and that two members of the unit staff were to be present at all times, helped to appease these fears to some extent. I also found drawing upon my recent experiences of conducting a stop smoking group in a school and on my past work experience of working with children helpful. Tailoring the material for a younger audience was not as difficult as I had anticipated, as, for example, I found the language I used similar to when providing smoking cessation support to clients whose first language is not English or individuals with lower educational ability. However, the experience was very different to developing training for healthcare professionals which is what I was used to.

2. Deliver such training programmes

As the workshop was very late in the day it was important I tried to keep energised and refreshed. I did some breathing exercises, as recommended by Siddons (2008), before arriving at the unit. As I had been doing clinics earlier in the day my voice was feeling a bit croaky but doing some voice warm up exercises and drinking lots of water helped.

I arrived at the unit an hour before the workshop. This was done to ensure enough time to set-up and test the IT equipment, as recommended by Race and Smith (1996), and also to informally meet with some of the young people beforehand to help recruit attendees for the workshop. Some of the young people who were busy preparing the evening meal came into my room to enquire about the workshop while I was setting up. I welcomed them and managed to enlist their assistance in preparing the room, which served as a good ice-breaker. When they saw some of the training materials, such as the tar jar prop, this helped to engage them. They even used it as a way of enticing their friends to attend the workshop.

The seating was arranged in a semi-circular formation to create an informal atmosphere and encourage discussion (Marx et al., 1999). The intention was to create a different environment to the academic settings the young people may have been more used to. They did however move to tables for the group activities.

When the young people arrived for the workshop I made eye-contact with each of them and greeted them with a handshake and smile to help establish rapport, which is particularly important at the start of any teaching or training session when trust maybe low and anxiety high amongst the group (Heron, 1999). Fortunately the numbers expected to attended the workshop all turned up so I did not have to make changes to the schedule.

The young people were very lively and animated which was great for the discussions and group activities. However, there were times when they would become distracted and I had to steer them back to the agenda, for example, when the lively banter would go off topic or too much time was being spent on one topic. I mentioned it was great they were so enthusiastic but outlined the time constraints and mentioned maybe it was something we could talk further about at the end of the session. I initially felt apprehensive doing this but kept my tone light and friendly, which seemed to work. I was conscious to praise the young people for good participation, for example, with the provision of correct answers in the quiz,

which is recommended to enhance learning and motivation (Alderman, 2004). When wrong answers were given, in an effort to make the situation more comfortable for the respondent, I would empathise by saying I could see why they would say that and ask the rest of the audience if they agreed, in effect opening it up to the rest of the group or remark that it was a particularly tricky question. Also I tried to keep an open posture and made sure I projected my voice throughout (Verderber, 2008).

2.1. Reflection on delivering a training programme

I found doing the deep breathing and the vocal exercises prior to the session very beneficial. Having the chance to meet up with some of the audience members prior to the start of the session was also a good ice breaker and helped me feel more relaxed about carrying out the workshop. It was interesting to watch the entrance of the young people which was very different from the adult health professional audience I was used to training. Some of them were reluctant to engage in eye contact and their body language appeared disengaged. However, bearing in mind the age of the young people I realised this was not unusual behaviour and should not be interpreted in the same way as for adults. This disengaged body language continued into the session which was difficult to deal with because as a presenter you often rely on bodily cues from the audience for feedback. After a while though I grew accustomed to it and it did not affect me as much.

I was nervous about intervening when some of the young people became too over excitable. I felt that I should have established some ground rules at the start of the session which would have explicitly outlined the behaviour expected of all parties and is something I would do in future sessions. My concern was not to ruin the flow of the group dynamic by chastising all the time yet at the same time I was mindful that the learning of others was being

disturbed. Fortunately I was able to deal with the situation without alienating any of the young people, by outlining the learning objectives they had expressed at the outset and explaining the limited time I had to meet them. They were respectful of this and in the end I found delivering the workshop to be a rewarding experience.

3. Plan and implement assessment procedures for such training programmes

To assess whether the learning objectives of the programme had been met, an evaluation form was developed for the young people to complete at the end of the session. This partly consisted of a 5 point Likert scale indicating whether there had been improvement in knowledge on the effects of smoking, smoking as an addiction and smoking cessation (refer to appendix 5). To ensure all the audience members understood the questions properly I read each of the statements aloud and then the young people noted their responses on their forms.

Results indicated that the learning objectives to improve knowledge on the effects of smoking, smoking as an addiction and smoking cessation were met. The knowledge of all the young people attending the session had improved ‘very much so’ and ‘quite a lot’ with regards to health effects of smoking, effects of passive smoking, the wider effects of smoking, counterfeit cigarettes, the tobacco industry, smoking as an addiction, smoking cessation methods and access to smoking cessation services.

The expectations that the young people had expressed regarding the workshop at the start of the session were also revisited at the end. All the expectations they had expressed regarding learning objectives, including, for example, wanting to acquire knowledge on smoking cessations methods, were met. Also the smokers in the audience who had expressed a desire to quit to the Unit Manager prior to workshop were informally asked their views on

quitting and cessation services by the Unit Manager after the workshop. All the responses were positive and the individuals stated they were now able to make an informed decision regarding any future quit attempts.

4. Evaluate such training programmes

The evaluation form was also developed to obtain the young peoples' views on all elements of the workshop. This included the use of open and close ended questions in a simple, user-friendly layout, as recommended by Race and Smith (1996). For example, respondents were asked to rate how useful they found each part of the workshop and if there was anything else they would have liked included into the workshop (refer to appendix 5). Results indicated that all of the 15 young people found all sections of the workshop to be 'very useful' or 'useful'. With regards to the most useful part of the workshop, this mainly consisted of the quiz, which 8 respondents (53%) mentioned. None of the respondents found any parts of the workshop the least useful. Finally, recommendations for improvement consisted of a longer session with role-plays and the opportunity to try Nicotine Replacement Therapy products.

Also verbal feedback was obtained from other members of the unit staff present at the workshop. They stated it was refreshing for them not have to get involved in the workshop, indicating to them that the young people were very engaged and enjoyed the workshop. This was supported by the verbal feedback provided by the young people themselves at the end of the session.

The development of future links between the organisation and stop service is also indicative of the 'success' of the training programme. The Manager of the unit was keen for

my service to do further workshops in the future and for the possibility of our soon-to-be-in-post youth stop smoking advisor to carry out a stop smoking group at the unit.

3.1./4.1.Reflection on planning and implementing assessment procedures and evaluating training programme

When developing suitable assessment and evaluation procedures for the workshop I found that the methods I was considering were not that dissimilar to those used for an adult audience. The only thing I did slightly differently, which I may not have done with an adult audience, was to read through the questions on the assessment and evaluation forms. I was always aware of and conscious not to patronise my audience, which I felt was a trap I could easily fall into given the age of the audience. However, given the feedback received from the evaluation forms, fortunately this did not happen.

It can be difficult when developing appropriate assessment methods and I found it useful to keep referring back to the original aim and learning objectives of the teaching/training session. It is possible to get too ambitious with the assessment and evaluation procedures and so I found it important to keep them within context of the original objectives.

I value both the more subjective and more objective evaluation measures equally as I feel that when they are combined I get as comprehensive a viewpoint as possible on the outcome of the teaching/training session. It was positive that all the young people who attended felt their learning objectives had been met and that the workshop was useful for them. With regards to the recommendations proposed, unfortunately the time limit in this case had been constrained but having a longer session during a different part of the day was something the Unit Manager considered for the future. Also with regards to providing

Nicotine Replacement Therapy samples for the young people that was something I was not legally able to do, which the young people understood once I explained it to them.

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Appendices

Appendix 1

Needs Assessment and Learning Objectives

Activity	**Needs Assessment and Learning Objectives**
Phone discussions with the Unit Manager	The Manager mentioned how the unit regularly provided health events for the young people and because a significant number of young people smoked at the unit she felt it would be an appropriate topic for their next workshop. She highlighted that the age range of young people at the unit was between 13-18 years and specified that the session would need to be engaging for the whole audience and conducted at a level they could all understand. She spoke about the challenging behaviour of the residents and mentioned that this would need to be considered in regards to how I developed the session. She mentioned how a sit down presentation for an hour, for example, would not be appropriate, as the young people would not be engaged. A period of one hour was specified for the workshop and I was informed it would take place just prior to the young peoples' evening meal. Numbers attending could not be guaranteed due to the unpredictable nature of the young people but it was estimated 15 individuals would be attending the event. Two members of staff from the unit were also to be present with me during the workshop for health and safety reasons. The learning objectives identified were to provide the young people with knowledge on the effects of smoking and cessation methods. This is because the young people had outlined to the Manager that they wished to learn more about the effects of smoking and also the best ways of quitting smoking. An audience profile was also developed by asking the Unit Manager if attendance was mandatory or voluntary and the number of smokers compared to non-smokers in the audience. She said that attendance was voluntary and that she knew for definite that about 8 of the expected young people smoked. Unfortunately time constraints did not allow for a meeting with the young people themselves.
Discussion of expectations from the workshop by the young people at the start of the workshop.	Learning objectives were also identified by asking the young people their expectations regarding the workshop at the start of the session, which were also revisited at the end of the session to ensure they had been met.

Appendix 2

Smoking Quiz

1. How many people die every day from smoking in the UK? The same as…

a. **a car full of people**
b. **a bus full of people**
c. **a jumbo jet plane full of people**

2. How many children start smoking every day in the UK, according to the charity Action on Smoking and Health (ASH)?

a. **250**
b. **450**
c. **750**

3. What does smoking do?

a. **Makes your skin dry and wrinkly**
b. **Increases your chance of getting cancer and heart disease**
c. **Costs about £1000 a year for a 10 a day smoker**

4. Smokers in the UK throw away 200 million cigarette butts a day.

a. **True**
b. **False**

5. Non-smokers can get lung cancer from being in other peoples' smoke

a. **True**
b. **False**

6. Cigarette smoke contains

a. **50 chemicals**
b. **500 chemicals**
c. **over 4000 chemicals**

7. What makes smoking addictive?

a. **Nicotine**
b. **It makes you look cool**
c. **It tastes nice**

8. When someone gives up smoking their body starts to recover within:

a. **2 weeks**
b. **2 months**
c. **20 minutes**

Appendix 3

Presentation Slides Handouts

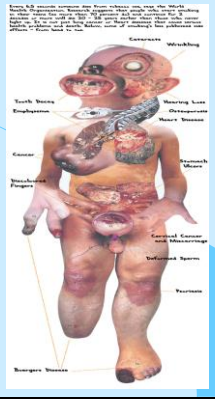
Stop Smoking Presentation

by
Riba Kalhar

Health Psychologist in Training
Smokefree ****, ****** PCT**

Health Effects of Smoking:

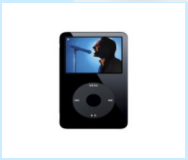
Ageing

Financial Cost of Smoking

10 cigarettes a day/ £1000 a year





= £1000

Buying Cigarettes

Since October 2007 it is illegal for under 18s to buy cigarettes

Counterfeit Cigarettes

Counterfeit Cigarettes

- Underworld, drug smuggling, prostitution etc

Tobacco Industry

- Environmental impact of tobacco industry- farmers and green tobacco sickness, pesticides, deforestation, litter from butts
- Advertising and promotion – tobacco companies' targeting of youth

Passive Smoking



Contents of a Cigarette

Cigarette smoke contains **4200 chemicals**. The main components of a cigarette are:

- Nicotine
- Tar
- Carbon monoxide

Why is Stopping Smoking Difficult?

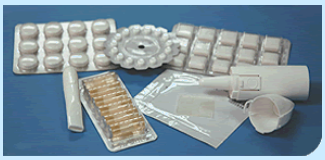
- **Addictive nature of Nicotine**
- **Habit side of smoking**

Nicotine Withdrawal Symptoms

Symptom	Duration	Incidence (%)
Lightheadedness	<48 hours	10
Sleep disturbance	<1 week	25
Poor concentration	<2 weeks	60
Craving for nicotine	<2 weeks	70
Irritability or aggression	<4 weeks	50
Depression	<4 weeks	60
Restlessness	<4 weeks	60
Increased appetite	<10 weeks	70

Ways to Stop Smoking

- Nicotine Replacement Therapy (NRT)
- 2 times more likely to quit than with willpower alone.



Call Smokefree ******

- Get support from a stop smoking advisor along with Nicotine Replacement Therapy on prescription.
- Makes you 4 times more likely to quit successfully than with willpower alone
- **FREEPHONE: 0800 ********

-

Any Questions?

Appendix 4

Stop Smoking Workshop Programme

- **Introductions**
- **Expectations from the workshop**
- **Quiz**
- **Presentation**
- **Role-plays**
- **Discussion**
- **Evaluation**

Appendix 5

Evaluation Form- Stop Smoking Workshop

What is your age? _____

Are you a smoker? Yes ☐ No ☐

1. How useful did you find the following parts of the workshop? (Please circle)

a) The quiz

Very Useful Useful Neutral Not very useful Not at all useful

b) Presentation

Very Useful Useful Neutral Not very useful Not at all useful

c) Role-play

Very Useful Useful Neutral Not very useful Not at all useful

d) Group discussion

Very Useful Useful Neutral Not very useful Not at all useful

2. What part of the workshop did you find the most useful?

_____

_____

3. What part of the workshop did you find the least useful?

_____

_____

4. Was there anything else you would have liked included in this workshop?

_____

_____

5. Do you feel you know more about the health effects of smoking?

Very much so Quite a lot Unsure Not much Not at all

6. Do you feel you know more about the effects of passive smoking?

Very much so Quite a lot Unsure Not much Not at all

7. Do you feel you know more about some of the wider effects of smoking, such as the financial costs?

Very much so Quite a lot Unsure Not much Not at all

8. Do you feel you know more about counterfeit cigarettes?

Very much so Quite a lot Unsure Not much Not at all

9. Do you feel you know more about the tobacco industry?

Very much so Quite a lot Unsure Not much Not at all

10. Do you know feel you know more about why smoking is addictive?

Very much so Quite a lot Unsure Not much Not at all

11. Do you know feel you know more about ways to stop smoking?

Very much so Quite a lot Unsure Not much Not at all

12. Do you know how to get support to help you (or somebody you know) to stop smoking?

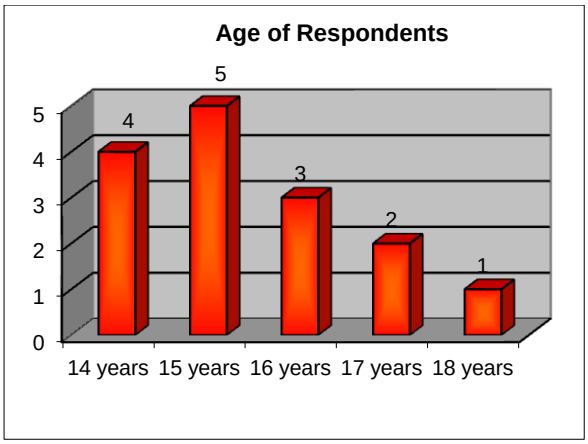
Very much so Quite a lot Unsure Not much Not at all

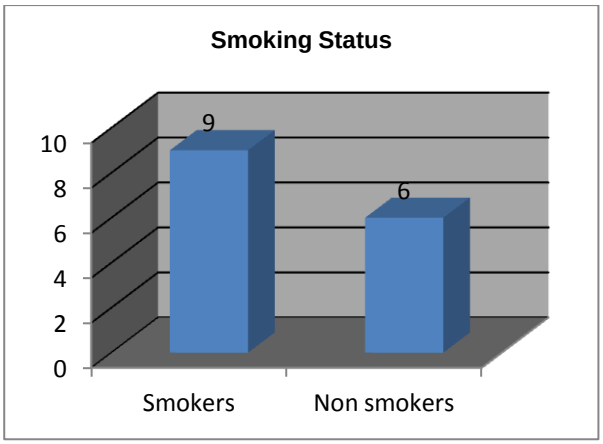
13. Any other comments

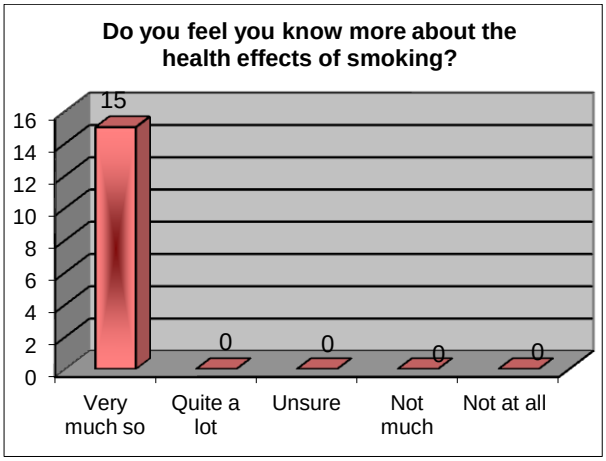
Thank You!

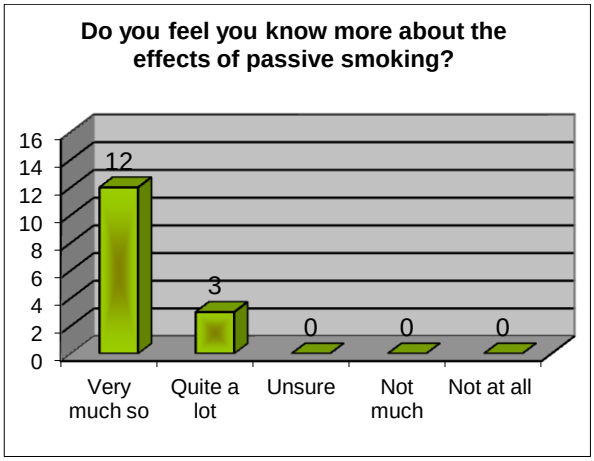
Appendix 6

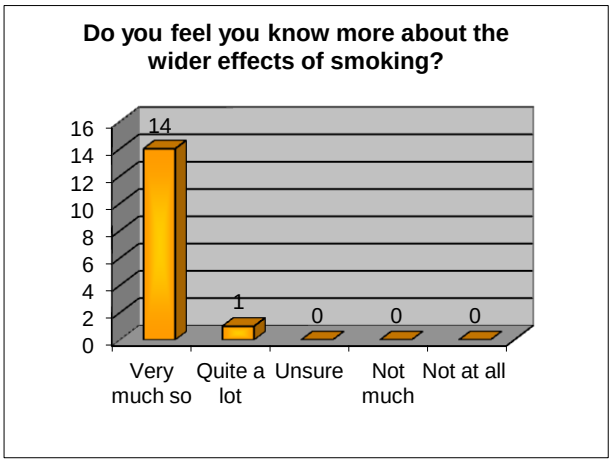
Results of Evaluation

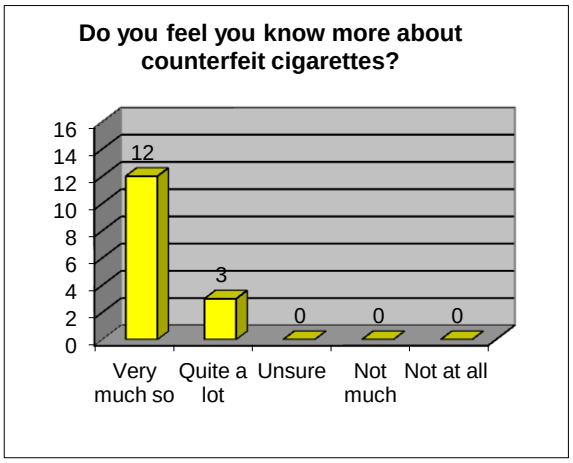




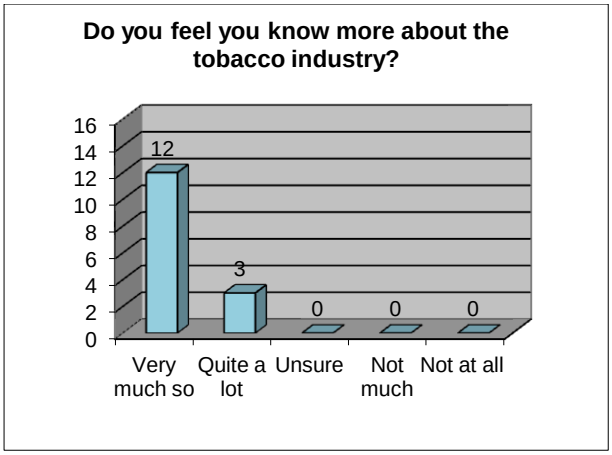


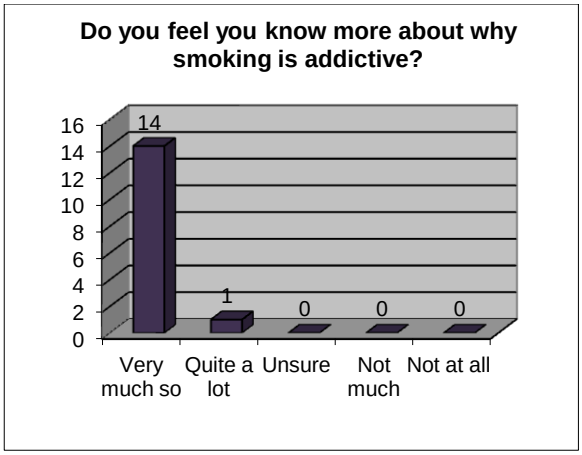


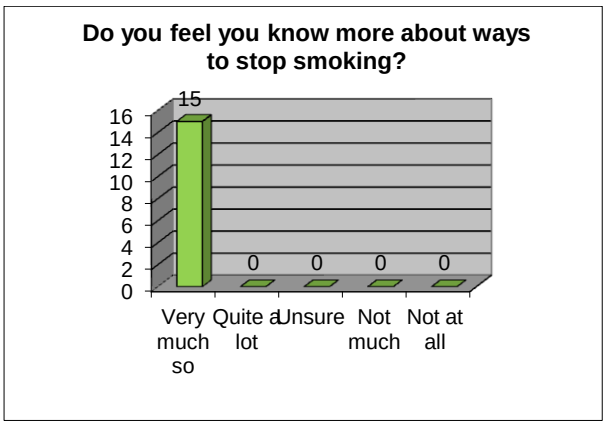


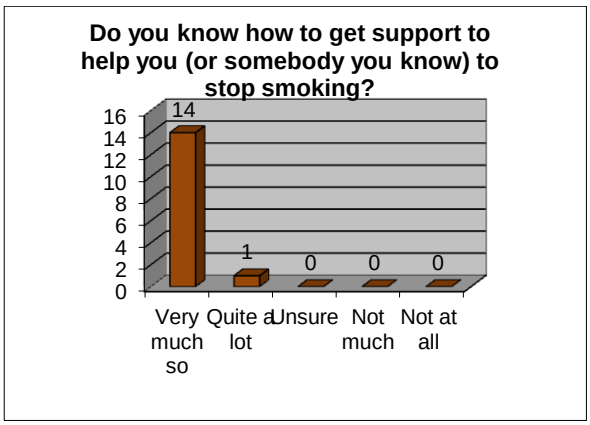


Stop Smoking Workshop for Young People

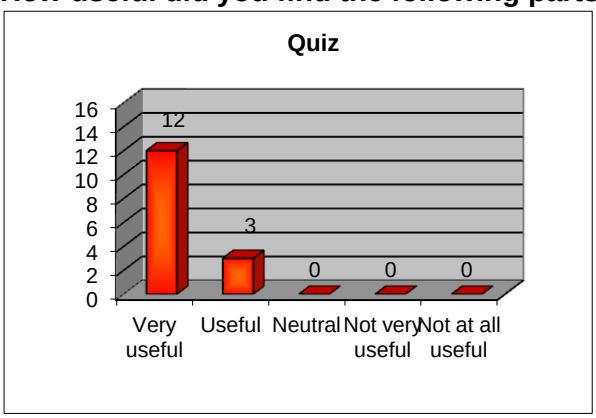


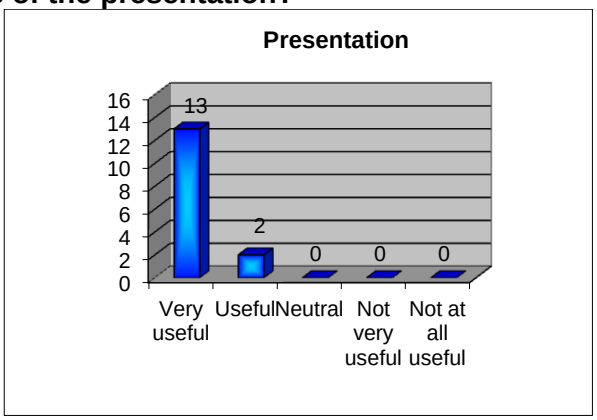


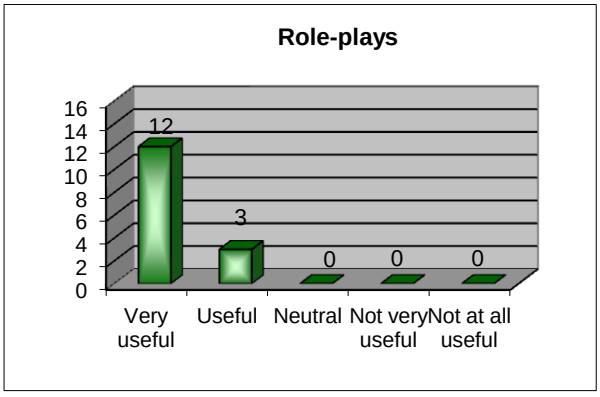


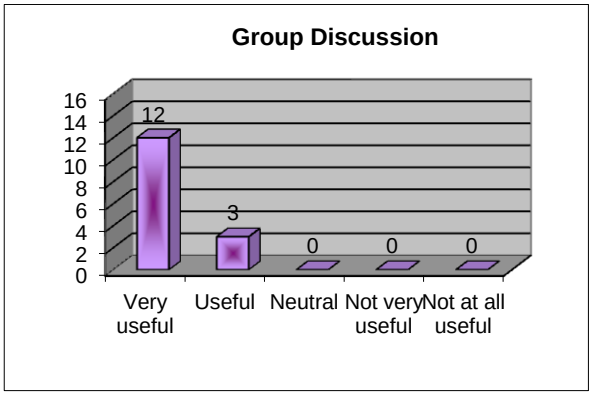


How useful did you find the following parts of the presentation?









What part of the workshop did you find most useful?

- The quiz
- Presentation
- All of it
- The quiz
- The quiz
- Role-plays
- The quiz
- The quiz
- The quiz
- The quiz
- Presentation
- Presentation
- Role-plays
- The quiz
- Presentation

What part of the workshop did you find the least useful?

- All did not find any of it least useful

Was there anything else you would have liked included in this workshop?
-Would have liked to be able to try some of the NRT products

- Would have liked a longer session with more role-plays

<u>Overview of Evaluation</u>

- Overall it can be seen that the majority of the respondents were aged between 14-15 years (60%) and smokers (60%). All the respondents indicated that their knowledge had improved 'very much so' and 'quite a lot' with regards to health effects of smoking, effects of passive smoking, the wider effects of smoking, counterfeit cigarettes, the tobacco industry, smoking as an addiction, smoking cessation methods and access to smoking cessation services.
- Also all of the 15 respondents found all sections of the workshop 'very useful' or 'useful'.
- With regards to the most useful part of the workshop this mainly consisted of the quiz, with 8 respondents mentioning it (53%).
- None of the respondents found any parts of the workshop the least useful.
- Recommendations for improvement consisted of a longer session with role-plays and the opportunity to try Nicotine Replacement Therapy products.

SECTION C

PROFESSIONAL PRACTICE

CONSULTANCY COMPETENCE

Ramadan Campaign Consultancy Project

CONSULTANCY COMPETENCE: RAMADAN CAMPAIGN CONSULTANCY PROJECT

1. Assessment of the request for consultancy and the identification of the 'client'

The initial request for the consultancy arose during an introductory meeting I had with the Project Improvement Officer (PIO) from the Health Promotion Department, to discuss the Ramadan Campaign we were to work on jointly later in the year.

The Ramadan Campaign takes place during the Muslim month of Ramadan when Muslims fast from dawn to dusk and refrain from activities damaging to their health. It is considered an ideal time to encourage Muslim smokers to quit smoking due to i) increased receptivity to messages related to spiritual and physical well-being within a holistic approach to health and ii) pragmatic factors, such as increased attendance among mosque-goers and a feasible means of reaching groups that are perceived to be 'hard-to-reach' by healthcare services (Netto et al., 2008). In July 2004 the Department of Health agreed new Public Service Agreement targets with the Treasury. These included tackling the underlying determinants of ill health and health inequalities by reducing adult smoking rates to 21% or less by 2010 and reducing smoking prevalence among routine and manual groups to 26% or less. A document produced by The Department for Communities and Local Government (2008), entitled 'Working with Black and Ethnic Minority Communities: a Guide for Stop Smoking Managers,' outlined that greater measures by Stop Smoking Services needed to be implemented to ensure accessibility by individuals from Black and Minority Ethnic groups (BME). My role at the Stop Smoking Service included being lead for BME groups, in an effort to address disparities in access and encourage greater referrals from individuals from different ethnic groups. I had recently been employed into this post when I was asked by my

Manager, who was the Head of the Stop Smoking Service (HSS) to assist the PIO with the campaign.

In our introductory meeting the PIO mentioned that he had been working on the Ramadan Campaign for the past three years but felt it was not as successful as it could be. Although he felt the local Muslim community's knowledge and awareness on the effects of smoking and cessation methods had improved (determined through anecdotal reports as opposed to verification through objective measures), he was disappointed with the lack of referrals to the Stop Smoking Service. He had also been given directions from his Manager, the Head of the Health Promotion Department (HHPD) and the HSS (who provided the budget for the campaign) to increase referrals to the service. Hence he was hoping to improve on the campaign's success this year with my assistance. I proposed this piece of work to him as a potential consultancy project and he agreed to this collaboration. This consultancy project was based on the process-consultation model devised by Schein (1999).

2. Preparation of the proposal

Our first official meeting to discuss the campaign constituted the initial exploratory meeting of the consultancy (Schein, 1999). Schein (1999) recommends this is attended by a person who owns a problem and requires help, which was representative of the PIO. In the meeting I attempted to establish the feasibility of the consultancy project. This involved conducting a more in-depth investigation of the PIO's problem, his expectations regarding my involvement and assessing whether I could help with the problem (Schein, 1999). The aim at this point was not to start identifying solutions to existing problems but to evaluate the scope of problems. Also although no fees were being paid for my services because this work was already part of my job description, we discussed supplementary fees to cover for the

exploratory sessions. This is because as Schein (1999) states, such meetings involve the invaluable resource of time for the consultant and useful insights can be gained for the client from such meetings.

I also met individually with the HSS and the HHPD who were the other key personnel involved with the consultancy, to get as comprehensive a view of the issues as possible. Also as Schein (1999) recommends, exploratory meetings should be attended by a person who possesses the capability to influence the organisation. A joint meeting was not possible to arrange and I felt that meeting them individually may also allow for a more honest and open exchanging of views. I hoped this would be one of the advantages of this being an internal consultancy, as outlined by Lacey (1995), whereby the clients would not have to adjust to the presence of an outsider and question my understanding of the culture of the organisation. Although I was aware this could also have its disadvantages with regards to my personal biases and preconceptions of the organisation, which I needed to be aware of and manage.

Overall there was a general consensus amongst the key personnel that the campaign had not been successful enough in past years. However, there were conflicts about the reasons for the lack of success. For example, the HSS felt a potential conflict in interest between the Stop Smoking Service and Health Promotion Department may have been a contributory factor, whereas the HHPD felt the focus had been on gaining referrals but the measures employed were inappropriate. It became apparent that there were a number of organisational and individual forces coming into play leading to task and power conflict between the HSS and HPD. Task conflict has been referred to as:

> "a perception of disagreement among group members or individuals about the content of their decisions, and involves differences in viewpoints, ideas and opinions. Examples of task conflict are conflicts about the distribution of resources, about

> procedures or guidelines, and the interpretation of facts." (Medina et al., 2005; pg. 220).

The HSS was focused primarily on generating referrals for the Stop Smoking Service from the campaign and the HPD was concerned with wider health promotion activity. Also there appeared to be power conflict, which has been described as occurring when each party wishes to maintain or maximize the amount of influence that it exerts in the relationship and the social setting (Katz, 1965). This occurred as a result of the HSS holding the financial budget for the campaign, even though it was to be used to fund the campaign activities of both the HSS and HPD's departments. There also appeared to be defensiveness and resistance among both parties to assume responsibility for the past results of the campaign, with a tendency to hold the other to account. These factors were influencing both parties' current interpretation of how the campaign should proceed and I realised this could present as a potential barrier in the consultancy.

The positive aspect was that there appeared to be a range of measures that had not been implemented in the past, which could be utilised to help address these issues. De Dreu and Van Vianen (2001), state that studies investigating ways of handling conflict, generally indicate that collaboration (which involves working out mutually acceptable solutions), as opposed to contending (which involves trying to impose ones' will and perspectives upon others) and avoidance (ignoring the problem), increases individual and team effectiveness. Also transparency in working is considered key as it implies democracy and the sharing of information (Lapalombara, 2003). Therefore I was keen to maintain an open dialogue between key personnel and gain shared agreement on all actions and the whole process was to be explicitly documented throughout, for example, through minute-taking of all meetings and regular dissemination of reports on progress.

At the end of initial discussions with key personnel all the clients involved in the process were assigned according to Schein's concept of clients. The PIO was identified as the contact and primary client because he made first contact with me and ultimately 'owned' the issue being worked on. The HHPD and HSS were identified as the intermediate clients as they would be involved in regular meetings as the project evolved.

With regards to establishing my role in the consultancy process, as this would be my first experience of working on a public health campaign, there was not a natural temptation for me to fall into the expert model or doctor/patient model (Schein, 1999). Schein (1999) describes the expert model as the purchase of expert information and the doctor/patient model as diagnosing the problem and prescribing recommendations. I felt this was beneficial for this consultancy because it was clear the client wanted to be involved in the whole decision-making process and wanted the two of us to work together as opposed to me providing solutions in isolation. So my approach was more in-keeping with the process consultation model (Schein, 1999), whereby I would help provide insight for the PC but the PC would also be pro-active in the process.

Discussions around timing of the consultancy project were not too complex because they were mainly dictated by the Ramadan period. It was agreed my services were required before the start of Ramadan for preparation purposes, during the month of Ramadan and for a period after Ramadan for evaluation purposes. The exact timings were to be defined at the contracting stage. As this consultancy was part of my job role I knew I was able to commit for the required length of time.

3. Process of developing the consultancy contract

Ramadan Campaign Consultancy Project

After the initial meetings with the primary client (PC) and intermediate clients (ICs) where I established the nature of what needed to be achieved with the campaign, the contract began to develop. The starting point was to establish an aim for the consultancy project, which was to be dictated by the aims of the campaign. It had been agreed by the PC and ICs that part of the problem in the past had been lack of a clearly-defined aim for the campaign and they indicated what they would like to achieve this year. I had to manage these expectations yet at the same time ensure the aim was feasible. For example, there was a desire to increase referrals to the Stop Smoking Service from the local Muslim population. I was aware how difficult it can be to elicit actual behaviour change, especially within a large population in such a limited time span with limited finances. So I suggested limiting an increase of referrals specifically to the Bangladeshi community, given that it is the largest Muslim ethnic minority population in the borough at 6.4% (Office for National Statistics, 2001) and more specifically to Bangladeshi men who have the highest adult smoking rates in the country at 40% (The National Health Service Information Centre, 2006). The PC saw the benefits of this because it still met the objectives outlined by the ICs, yet gave him a more specific direction to follow. Overall the aims agreed were to:

- promote the harmful effects of smoking and Stop Smoking Services to the local Muslim population
- increase the number of Bangladeshi men accessing the Stop Smoking Service in comparison to the previous year

When defining the objectives of the consultancy I had to firstly increase my knowledge regarding previous campaigns because I did not have prior knowledge or experience of how the campaign had been run in the past. Schein (1999) describes the importance of 'accessing your ignorance' whereby you make the effort to distinguish what

you know about and what you should be asking about. Hence I asked questions at the initial exploratory meetings I had with the clients and at further meetings with the PC, along with reading all reports on previous campaigns to try to establish what needed to be done this time around. I encountered conflicts amongst the client in regards to setting objectives, which I needed to help resolve. For example, the HSS felt there was too much of an emphasis on mosque activities in the previous campaign and the focus needed to be broadened into the community, whereas the PC felt given the religious ethos of the campaign, the mosques were an appropriate focal point. To help me deal with this conflict, again I sought to increase my awareness first, for example, by asking how many people were reached through the mosques in past campaigns. I established the mosques had been a good recruiting ground to access large numbers of people to attend smoking cessation talks; however, there had been little follow up work to help those people interested in quitting to access cessation services. When this was relayed back to the HSS she agreed to keep the focus on the mosques but to carry out greater follow-up work. This was good because I negotiated a feasible objective for myself while keeping both the HSS and PC satisfied. Working in this collaborative way and keeping all parties in agreement was representative of how I worked within the process consultation model discussed earlier.

With regards to the objectives, these included to identify effective campaigning methods to encourage smoking cessation amongst the Bangladeshi community (through conducting health psychology literature reviews and focus groups), assist in implementing these methods (through mosque, media and wider community activities) and to develop and conduct processes to monitor and evaluate the outcomes of these methods.

Not all of the duties that I was going to undertake to meet the objectives were finalised in the early stages. This is because they were dependent on the outcome of the focus groups and literature reviews I was going to carry out. When these were completed the

contract was reviewed. As this consultancy work was part of my job description, the fees for my service were not an influencing factor in the review stage but what was paramount for the clients was that I kept the work within the agreed boundaries in regards to timeframe, budget and resources available for the campaign. Also it was ensured all reviews were in-keeping with the ICs' wishes, particularly the HSS who was providing the budget for the campaign. The length of time for the consultancy was also finalised after all duties to meet the objectives were outlined. When establishing a time period it was predominantly influenced by the PC's past experience of running the campaign. Overall a five month period was decided upon to allow for two months preparation for the campaign, one month for the campaign period over Ramadan and two months for follow-up and evaluation purposes. Although no fees were exchanged for this consultancy work the billing on the contract was calculated on a weekly rate. The length of time required for each task was calculated through past experience of conducting similar tasks and getting the PC's views on how long the tasks had taken in previous campaigns. The PC was satisfied with the content and signed the contract (see appendix 1 for contract).

4. Description and reflection on conducting consultancy; including setting up, maintaining and closing the contract.

4.1.Setting up stage

All three stages of the consultancy, including the setting up, maintaining and closing of the contract, involved close working with the PC. I was aware that the early stages in the consultancy were crucial in attempting to build a good relationship with the client, which can have such impact on the process and outcome of the consultancy (Larwood & Gattiker,

1986). The period of scoping the problem prior to negotiating the contract involved a lot of pre-inquiry on my part, which involved engaging in lots of active listening to try and be as helpful to the client as possible (Kenton et al., 2003). When setting up the contract I had to try to draw all my findings together and work in a more directive way with the client at times. However, the aim was always to develop a mutually-acceptable strategy that would lead to the desired outcome for the client. I was always mindful of trying to build a relationship with the client based on mutual trust and respect (Appelbaum & Steed, 2005), which involved keeping communication channels open and making my activity as overt as possible. Meetings were conducted with the PC on a weekly basis alongside frequent email and phone discussions, and the ICSs were informed regularly of developments, because as Smith (2002) states, good communication between the client, consultant and senior management is vital (refer to appendix 2 for examples of correspondence). All correspondence was recorded as much as possible and meetings minuted (refer to appendix 3 for examples of minutes). Also a GANTT chart was developed with the PC, which specified timeframes for the project to ensure each part of the process was completed in a timely fashion (refer to appendix 4) and all the activities were budgeted for to ensure the allocated £3,000 budget for the campaign was not exceeded (refer to appendix 5).

The PC acknowledged and appreciated the systematic approach and level of organisation that was being taken for the consultancy project. He admitted he was not used to working in such a way but was finding it beneficial as he now felt he had a clearer direction in his approach to the campaign. His willingness to learn was a positive facet to the process, which has been recognised as a quality which consultants value in clients (Kellogg, 1984).

4.2.Maintenance stage

As the consultancy progressed to the maintenance stage of the contract, challenges to this relationship were encountered. For example, one of the agreed consultancy requirements was for the PC to discuss campaign decisions with the consultant before implementing them. However, there were times he did not do this. I was wary about raising the subject with the PC due to fears of upsetting him or jeopardising our relationship. However, I realised that the contract had been drawn up in partnership with his agreement and that to assist in achieving the objectives I had to raise the issue. As Carucci and Tetenbaum (2000) describe, for a consultant to create value they have to be a 'truth-teller' who builds active and accurate feedback systems with the client. Therefore, I brought it to the PC's attention in a tactful and sensitive manner. The PC said he had not realised his actions, perhaps because he is so used to working on the campaign independently and the situation was resolved. In this case the client had not been consciously aware of his actions. I realised that it was important for me to be assertive as a consultant and to be able to voice my concerns in a suitable manner when I had them.

Having to deal effectively with resistance to change was also a feature in maintaining the contract (Freedman et al., 2001). This resistance was due to personal factors as opposed to organisational forces. For example, the PC appeared reluctant to engage wholeheartedly in some of the more novel activities developed for the campaign, despite us having developed them together and agreeing to their implementation in the contract. I was aware that the PC's usual practice of doing things may have been an influencing factor again and appreciated that learning to change can take time. However, as Fullerton and West (1996), suggest clients must take ownership of the problem being addressed and be willing to change according to the project's recommendations. Therefore I addressed the situation by trying to demonstrate

the positive outcomes of some of these new activities to help with the transition. Fortunately this assisted with the situation and the trust the PC had in the new ways of working.

At other times the barriers I encountered from the PC were more conscious. I noticed as the consultancy progressed that the PC's enthusiasm for the project began to waiver at times. On further questioning the PC confessed he did question the value of campaign as it only takes place for a month out of the year with little follow-up work afterwards. He felt resentful about the fact he puts a lot of hard work into the campaign but then is never provided with any funding to continue any follow up work. He mentioned that being a Bangladeshi male himself he felt he was letting his community down. Being a consultant I found I often had to change roles, for example, in this case I had to take on a counsellor role for a while (Schein, 1999). I felt it was positive that the PC felt able to confide in me about internal politics and other more personal issues as it indicated trust in our relationship yet at the same time I also felt a greater burden to resolve the situation to help with maintenance of the contract. However, as Schaffer (2002) states, 'beginning with results' is a key critical success factor in consultancy work, whereby clients need to assume ownership and recognise that success depends on them and to assume responsibility for this. So I brought the issue to his attention and I also drew upon my knowledge of the organisational culture and the conversations I had with the ICs, to help resolve the issue. Hence I was able to inform him that the funding issues resulted because he had not been able to objectively demonstrate the effectiveness of measures used in the campaign. However, as we had outcome measures in place this year to capture potential positive outcomes, this could potentially assist in securing future funding. He appreciated this and felt more optimistic about the campaign.

4.3.Closing stage

Overall the consultancy project did not encounter any fundamental changes and I was able to meet the overall aim and objectives of the contract. When compiling the final evaluation report for the project I obtained feedback from the PC and ICs who were satisfied with the progress and completion of the campaign. There were discussions over what the future recommendations should be from the consultancy. I was informed by my Manager before the start of the consultancy that I would be working on the campaign every year. Hence my position as an internal consultant meant I would be present in the organisation to help implement any changes and be involved in any follow up work. I felt this was beneficial in regards to the acceptance of the recommendations made, as there was not the feeling that I was an outsider giving my suggestions and then leaving the organisation to deal with the aftermath alone. I had more of a vested interest in the long-term which appeared to be advantageous. As Kubr (2002) states, one of the benefits of internal consultants is that they are more involved in discussing recommendations and monitoring implementation, and that their use can improve the quality of implementation quite considerably. In regards to implementing the changes I felt fortunate in not meeting much resistance to change. All the key personnel involved with the consultancy were keen in pursuing creative ideas for development; the barrier was more with not knowing how to proceed as opposed to being resistant to proceeding, which we were able to work through.

5. Description and reflection of how the process and outcomes were monitored

A number of measures were put into place to monitor the process and outcomes of the consultancy. Firstly, the PC was asked to complete an assessment at the end of the consultancy giving his feedback on the whole consultancy process (appendix 6). This

included remarking on the positive and negative aspects of the consultancy, what could have been done differently, my conduct in the consultancy, whether he would hire a consultant again, etc. This measure monitored the processes and outcomes of the consultancy from the client's point of view. Overall the feedback was very positive about the project and the client indicated feeling more empowered as a result of it. Earll and Bath (2004) state, that one method of evaluating consultancy work is through assessing client empowerment, whereby if a client feels better able and confident in their ability to deal with the issue in future then this is an indication of the project's success.

From a consultant's perspective it was very enlightening receiving this feedback from the client. This is because although you are working closely with the client throughout the consultancy process and have your own perceptions of how you think the process is progressing, there is still uncertainty over the client's perception. The client mentioned in his feedback about finding my methodical way of working an adjustment at first but grew accustomed to it after seeing its benefits. This made me think that in future I need to be more aware of the time it takes for clients to change their behaviour and to check back with them more frequently.

Outcomes regarding the aims of the project were monitored in a number of ways. The aims had been to promote the harmful effects of smoking and availability of Stop Smoking Services to the local Muslim population and to increase the number of Bangladeshi men accessing the Stop Smoking Service in comparison to the previous year.

With regards to promoting the harmful effects of smoking and availability of Stop Smoking Services to the local Muslim population, Imams in local mosques delivered sermons on the effects of smoking and services available, which were heard by a total of 1607 people. Also talks on smoking were conducted by the Community Outreach Workers in local mosques, which were frequented by large numbers of Bangladeshi, Somali and Turkish men

during the month of Ramadan. A form was developed which respondents completed at the end of the session asking them to rate the usefulness of the session, their motivation to quit smoking, their knowledge on how to quit smoking and their current intentions regarding quitting (appendix 7). Results indicated that a total of 249 people from six mosques attended the talks over the Ramadan month, with 90% finding the session very useful. The majority (92%) also said they had increased motivation to quit smoking after the talk and that they felt their knowledge on how to quit smoking had improved a lot (87%). 95% expressed a desire to stop smoking with the majority (74%) wishing to visit the local pharmacy for stop smoking support. Other promotional activities included delivering talks on smoking, tobacco chewing and cessation in community centres which were attended by 22 individuals, having two health bus sessions (manned by stop smoking advisors) in a busy Bangladeshi market area and media promotion on a national Asian radio station and satellite TV channel.

With regards to increasing referrals, all local pharmacies in the area were asked to complete a monitoring form for all people enquiring about stop smoking support over the Ramadan period (appendix 8). This form captured data on where the individual had heard about the Stop Smoking Service. If they had heard of it as a result of the Ramadan campaign then further information regarding the outcome was obtained (including whether they made an appointment, bought Nicotine Replacement Therapy, were referred elsewhere or other). If an appointment was made then they also had to indicate whether they attended. Also after the talks at the mosque sessions the Community Outreach Workers recorded details of all individuals interested in accessing stop smoking support (appendix 9), to help assist them make appointments with Stop Smoking Services. In total 48 Bangladeshi men attended their first appointments and set a quit date with Stop Smoking Services (in comparison to 0 the previous year). Of these 26 (54%) quit smoking, 7 (15%) did not quit and 15 (31%) were lost to follow up. Outcomes of other community activities (health bus sessions, community

centre talks, use of promotional materials) and media activities (national Asian radio jingles and studio discussion on national Bangladeshi satellite TV) were measured by i) referrals made directly to the Stop Smoking Service via their freephone and ii) assessment of the 'how did you hear about the service' section of the service monitoring forms, which are completed for all clients seen by local stop smoking advisors. In total 15 referrals were made from the community activities and 0 referrals from the media activities. Overall this campaign produced the highest number of referrals and quitters for the Stop Smoking Service since the Ramadan Campaign had commenced.

Recommendations for future campaigns were also made. Ford (1974) recommends that recommendations are feasible for the client to ensure successful implementation, which was ensured through discussion with the ICs and PCS. These included i) having a Specialist Bangladeshi Stop Smoking Advisor being based with the Specialist Stop Smoking Service due to language barriers, ii) having more Bangladeshi community-based advisors due to the successful use of Community Outreach Workers, iii) more localised community-based media activities as opposed to national media based ones, iv) commencing the campaign prior to start of Ramadan to allow smokers preparation time to quit before Ramadan starts and v) broadening the campaign to target younger people and Somalians as many young smokers were requesting assistance and the Somali population is a growing population in the borough.

A full evaluation report detailing the processes, outcomes and recommendations from the campaign was produced for the PC and the ICS (appendix 10).

6. Summary and overall reflection

The aims of the consultancy had been to assist the PC in meeting set targets for the Ramadan Campaign. This was done by using the process consultation model developed by Schein (1999). During the consultancy, barriers relating to organisational and individual forces, such as task conflict and resistance to change were encountered. However, working in partnership with the client, maintaining open communication channels and assisting the client to own the issues, helped to resolve these barriers and the aims of the consultancy project were met. Recommendations for future practice were outlined, which were accepted by the PC and the ICs. Implementation of the recommendations was to be a longer-term process and so results could not be determined immediately at the end of the consultancy.

Overall the process of conducting the consultancy project was challenging because it was my first experience of consultancy work. Working as an internal consultant on a project that was part of my existing job role meant there were two roles I was managing, one which was an employee for my Manager and another a consultant for the PC. This was difficult to negotiate at the start of the process. However, after the first couple of meetings I grew accustomed to organising myself accordingly. The positive aspect of this was also that at the end of the process I would be involved in implementing the recommendations. On a whole I found that using the process consultation model and working in partnership with the client to identify solutions was a very effective way of conducting consultancy work.

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Appendices

Appendix 1

CONTRACT FOR CONSULTANCY WORK

TITLE OF WORK: Planning, Delivering and Evaluating the 2006 Stop Smoking for Ramadan Campaign for [redacted]

CONTRACTING CLIENT: [redacted], Project Improvement Officer

CONSULTANT: Riba Kalhar, Health Psychologist in Training

BACKGROUND

The Consultant is a Health Psychologist in Training who is currently completing a full time doctorate course in Health Psychology at City University, London in addition to working full time as a Health Psychologist in Training at [redacted]. The contracting client also works at [redacted] as a Project Improvement Officer in the Health Promotion Department.

OBJECTIVES

The aim of the consultancy is to assist with the 2006 Ramadan Campaign in i) promoting the harmful effects of smoking and availability of smoking cessation services available to the [redacted] Muslim community and ii) increasing the number of Bangladeshi males accessing the Stop Smoking Service, compared to last year. The objectives are to identify effective campaigning methods to encourage smoking cessation amongst the Bangladeshi community, assist in implementing these methods and to develop and conduct processes to monitor and evaluate the outcomes of these methods.

In order to meet the above aims and objectives the following work will be undertaken:

Identification of effective campaigning methods:

- A literature review into health promotion campaigns targeted at the UK South Asian community
- A literature review into smoking cessation and the Bangladeshi population in the UK
- Undertaking 2 focus groups with Bangladeshi community groups

Developing partnership working:

- Developing partnership working with [redacted]
- Developing partnership working with [redacted] stop smoking service and identifying other appropriate stop smoking services

Developing and distributing promotional material:

- Assisting with the development and distribution of promotional campaign materials
- Preparing and equipping local healthcare services and community groups with necessary promotional resources

Carrying out preparation for campaign activities:

- Assisting with the organisation of level I training for local Imams
- Providing level II stop smoking support training to 2 male Bangladeshi outreach workers

Conducting campaign activities:

- Organising health bus sessions in the local community – assisting with location, dates, recruitment of helpers
- Assisting with media campaign – press releases, radio, television shows
- Organise paan chewing talks in the community for female Bangladeshis

Developing and executing evaluation measures:

- Development of questionnaire to measure knowledge and intentions regarding smoking cessation pre and post campaigning in mosques
- Implement measures to monitor referrals from the campaign to the Stop Smoking Service
- Compile full evaluation report

General responsibilities:

- Responsible for overseeing the outreach workers work in the local community (mosque stop smoking talks, devise content of talks)
- Responsible for overseeing budget of campaign

CONSULTANT REQUIREMENTS

- The Project Improvement Officer will be the main point of contact for the consultancy work
- The Project Improvement Officer will discuss any decisions regarding the campaign before implementing them, share contacts, aid with communication with the local community, provide requested information and assist with to ensure as smooth completion as possible to the end
- Regular contact will be maintained with the contracting client throughout
- [redacted] to make available PCT campaigning resources, electrical equipment, and fund transportation fees
- [redacted] Stop Smoking Service to provide budget for the campaign

TIMEFRAME

The duration for the intervention is 5 months

Start of consultancy: July 2006

End of consultancy: November 2006

CODE OF CONDUCT

The Consultant, Health Psychologist in Training will carry out the service in accordance with The British Psychological Society

INTELLECTUAL PROPERTY

The Consultant, Health Psychologist in Training shall be named on any publications arising from her work. This has to be discussed and agreed

CONFIDENTIALITY

During the course of the services the Health Psychologist in Training may have access to gain knowledge of or to be entrusted with information of a confidential nature. In signing this contract, the principal investigator agrees, unless expressly authorised by a senior authorised person to so, will not disclose to any unauthorised person or organisation any such confidential information. The Health Psychologist in Training agrees to store and process information in accordance with the Data Protection Act 1998

COST

This consultancy forms part of the consultant's job description and therefore no extra fees will be requested. If they were required the estimated fee would be budgeted at a total cost of £21,985 (52 weeks)

Breakdown of Cost	**Cost per week £423**
Identification of effective campaigning methods	1 week
Developing partnership working	6 days
Developing and distributing promotional material	2 weeks
Carrying out preparation for campaign activities	1 week
Conducting campaign activities	3 weeks
Developing and executing evaluation measures	1 week
General responsibilities	5 days

Signature..... Date.....

Consultant name (please print):
Health Psychologist in Training
[redacted] Stop Smoking Service, City University London

Signature..... Date.....

Client name (please print):
Project Improvement Officer
Health Promotion Department, [redacted]

Appendix 2

Examples of email correspondence with PC and ICs

From: [redacted]

Sent: 12 July 2006 10:45

To: Kalhar, Riba

Subject: Ramadan

Hi Riba

Thanks for letting me know about the focus groups. It will definitely be interesting to hear what they say. Once we've done that at least all the objectives can be finalised. I think we've got a meeting booked for next week so we can work on it then.

Regards

[redacted]

-----Original Message-----

From: [redacted]

Sent: 10 August 2006 11:31

To: Kalhar, Riba

Subject: [redacted]

Hi Riba

Have you had the chance to speak to [redacted] about it? I spoke to [redacted] and we need at least one of them to attend the talk and carry out sessions in community centres and health bus. Also apparently Fridays are best if we want to do health bus sessions in [redacted], so I booked the bus for the 22 & 29.

Regards

[redacted]

From: Kalhar, Riba

Sent: 10 August 2006 11:34

To: [redacted]

Subject:RE: [redacted]

Hi [redacted]

Yes, I just found out today that she's on annual leave but she will be back in a couple of days so I will call her then. That's great about the Health Bus, the dispensation procedure is really simple so that should be sorted out soon. I will get back to you as soon as I am able to contact [redacted] so we can move forward with this.

Regards

Riba

From: [redacted]

Sent: 10 August 2006 11:59

To: Kalhar, Riba

Subject: RE: [redacted]

Thanks

From: [redacted]

Sent: 30 August 2006 15:37

To: Kalhar, Riba

Subject:Imam's training

Hi Riba

At last I finalised the imams training dates, venue, cost etc with [redacted] mosques, [redacted] Centre and outreach workers. The training will be on 18 Sept at [redacted] Centre from 10am. We can discuss the programme tomorrow when we meet.

Thanks

[redacted]

-----Original Message-----

From: Kalhar, Riba

Sent: 15 November 2006 15:37

To: [redacted]

Subject: Mosque talks data

Hi [redacted]

Just to let you know I've nearly finished compiling the data outcomes for the report. Were you able to get the final figures from the community outreach workers for the mosque talks? Once I get that information I'll send you , [redacted] and [redacted], the draft for your comments, as agreed.

Thanks

Riba

From: [redacted]

Sent: 15 November 2006 16:41

To: Kalhar, Riba

Subject: RE: Mosque talks data

Hi Riba

Yes sorry meant to get you those earlier today but it's been one of those days! Please see attached.

Regards

[redacted]

-----Original Message-----

From: Kalhar, Riba

Sent:16 November 2006 13:21

To: [redacted]; [redacted]

Subject: Mosque talk quit rates

Dear [redacted] and [redacted]

Just to let you know we have accumulated the final figures regarding the setting of a quit date and quit rates. In total there were 48 people who set a quit date, 26 (54%) quit, 15 (31%) did not quit and 7 (15%) were lost to follow up. So the final quit figures were actually higher than we originally anticipated which is great news.

I'll add these figures into the evaluation I've done so far. I'll send the draft report out to you by tomorrow. I've organised a meeting for us all at the end of November as originally agreed, to discuss the recommendations from the campaign. Look forward to discussing this further with you then.

Best regards

Riba

From: [redacted]

Sent:16 November 2006 15:47

To: Kalhar, Riba

Subject: RE: Mosque talk quit rates

Hi Riba

That's absolutely fantastic news! Well done for that. It will be good to see the draft report. Yes the meeting is in my calendar. Look forward to meeting then.

Best wishes

[redacted]

Appendix 3

MINUTES

28/06/06	
ITEM	**ACTION**
Discussed past campaigns • Felt that there wasn't sufficient evaluation. • There have been [redacted]–wide campaigns conducted in the past, felt less control as it was more centrally coordinated. • Targeted the smoking message in association with illnesses such as CHD and diabetes • Referrals to stop smoking services were low This year's campaign • It will not be conducted centrally • The Stop smoking service has a £3,000 budget to conduct the campaign • Possibility of linking up with [redacted] PCT for shared promotional activity • Campaign involves prep prior to the month of Ramadan and time for evaluation after the month • Need to get arrange meetings with [redacted] and [redacted] to discuss aim of this year's campaign • [redacted] agreed to conducting the project as a consultancy – further discussions regarding aims and objectives to	RK to arrange meeting with [redacted] and [redacted]. RK to arrange next meeting with [redacted] following meeting with [redacted] and [redacted].

05/07/06	
ITEM	**ACTION**
Outcome of meeting with [redacted] and [redacted] discussed • Confirmation of £3,000 budget from the Stop Smoking Service • Needs to be a greater emphasis on evaluation • Aim of campaign has to increase referrals into the Stop Smoking Service and also provide health promotion on smoking to the community • Be creative with the campaign, don't have to repeat same activities just because we always do – as don't appear to effective	
This year's campaign • Aim - Instead of focusing on the whole Muslim community may be more feasible to focus on the Bangladeshi population for referrals • Health promotion work can be targeted at the wider community • Community outreach workers who have been level II trained have worked well in the past. Possibility of recruiting for this year. • Possibility of PHA participation, Access Bangladeshi women's [redacted], voluntary action group and [redacted]. • Reminders to Imams • Promotional calendar, media campaign, print promotional materials in GP practices, pharmacies and community centres	RK to discuss with [redacted] [redacted] to contact [redacted] Centre and [redacted] [redacted] to contact [redacted] to find out if funding available for this year for media campaign. [redacted] to email [redacted] promotional material from previous campaign.
• Discussion on having a stall on [redacted] market but felt the Health Bus would have more impact. • Level II training to be arranged for community outreach workers • Need to develop suitable outcome measures • Establish link with level II advisors in community who speak Muslim languages.	[redacted] to contact [redacted] Council RK to send details of level II training dates to [redacted] RK to follow up level II advisors

Ramadan Campaign Consultancy Project

Preliminary objectives for campaign/consultancy • RK to identify effective campaigning methods to encourage smoking cessation amongst the Bangladeshi community. Health psychology literature review into health promotion campaigns and effective cessation methods for the Bangladeshi community to inform aim and further objectives to be carried out. • RK to assist in implementing these methods • RK to develop and conduct processes to monitor and evaluate the outcomes of these methods.	
Plan • RK to review previous campaign reports • Was agreed need to make the campaign more evidence-based by reviewing literature into health promotion by RK • RK to also conduct focus groups with the local population to get an indication of effective promotional methods and preference for cessation services • Objectives to be finalised after literature review and outcome of focus groups • Objectives to then be discussed with [redacted] and [redacted]	RK to read previous reports RK to conduct literature review once aims agreed by [redacted] and [redacted] RK to organise focus groups once aims agreed by [redacted] and [redacted] Objectives to be finalised after lit review and focus groups by RK and [redacted]
Preliminary GANTT chart for campaign drafted	RK to type up GANTT chart

10/07/06	
ITEM	**ACTION**
Outcome of discussions with [redacted] and [redacted] after literature review: • Aims agreed by [redacted] and [redacted] to focus on Bangladeshi males with regards to referrals to stop smoking services • They're happy for focus groups to proceed • Was discussed with [redacted] that would still like to maintain mosque activities after RK's literature review as feel have a large captive audience which hasn't been targeted effectively in the past. Mentioned the Community Outreach workers would play a more instrumental role between bridging the gap between the community and our service.	
Contract for consultancy agreed and signed – objectives to be revised following outcomes of focus groups and discussions with [redacted] and [redacted]	RK to revise contract accordingly
Taking campaign forward • Focus groups to be conducted at [redacted] centre to help finalise objectives	RK to arrange two dates with the centre for focus groups

17/07/06	
ITEM	**ACTION**
Outcome of focus groups: • The two groups consisting of Bangladeshi male smokers ranging in age from 30-65 years were keen about the campaign. • They said there was a desire to quit smoking but uncertainty regarding the best way to quit. • Many had tried to use willpower and failed. There was conflict regarding the use of NRT with many thinking the use of NRT was forbidden during Ramadan (when fasting takes place). • They felt if there were Imams advocating the use, and it should be treated like a medicine this would be useful. • Language barriers were issues with some of the individuals in regards to accessing stop smoking services and said they would make use of the service now that they knew Bengali speaking advisors were available. • They also mentioned uncertainty on how to access the service and liked the idea of community outreach workers offering guidance and support to them. • They recommended the use of promotional materials, particularly the wallet cards, especially if you're trying to stop smoking.	
Objectives for campaign/consultancy: • Mosque activities – participate in [redacted] funded health training event with Imams for Ramadan, outreach workers to link between mosque and us, level II trained outreach workers to provide special stop smoking talks in the mosque and identify individuals interested in quitting with smokefree services. • Employment of 2 outreach workers • • Promotional activities - link up with [redacted] from [redacted] PCT regarding	[redacted] to contact [redacted] re: event in mosque [redacted] to initiate recruitment of outreach workers and liaise with RK RK to arrange meeting with [redacted]

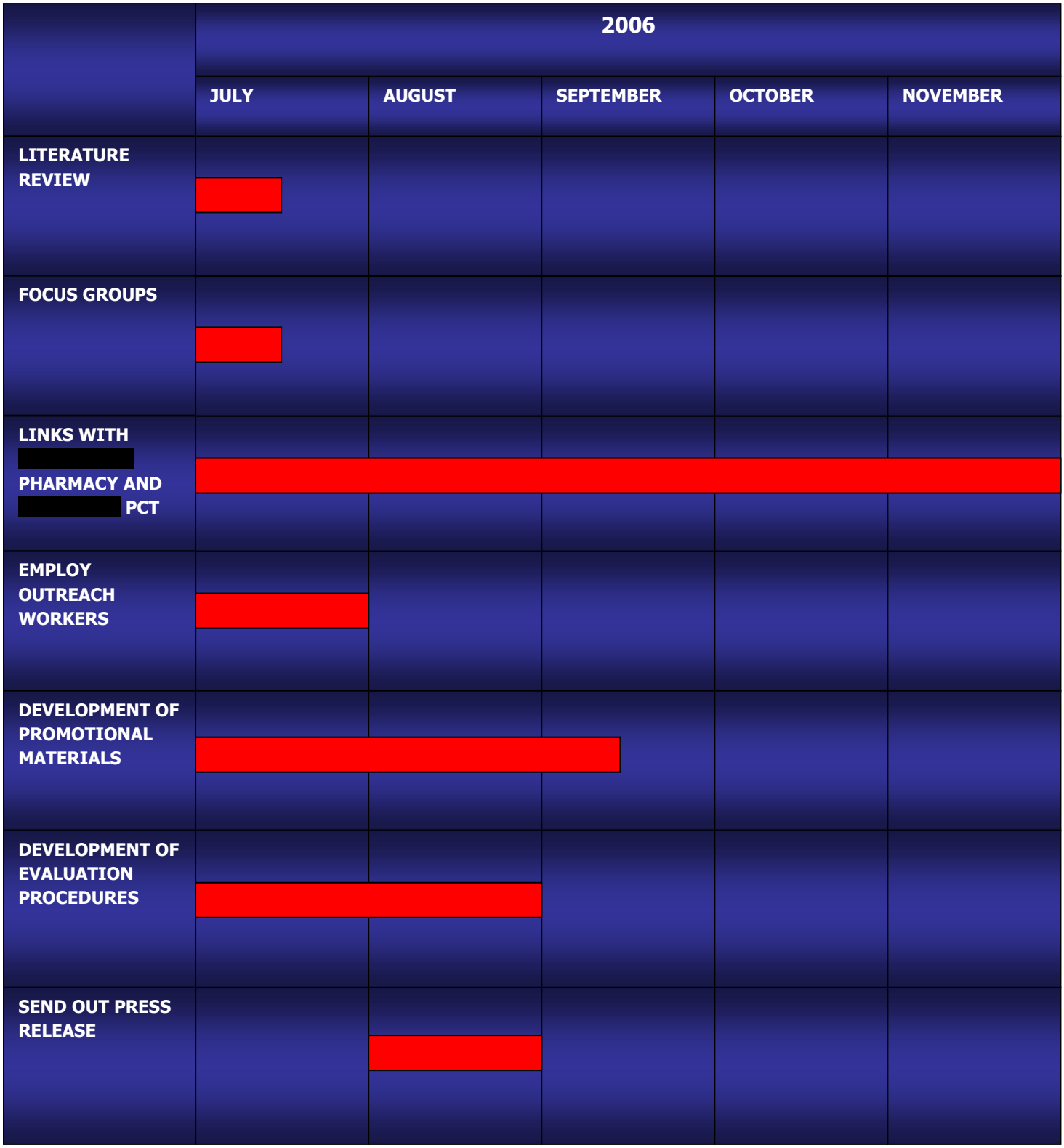
shared promo. Develop posters, leaflets and wallets	[redacted] to check costings for wallet cards and commence design of poster
Contract	RK to present objectives to [redacted] and [redacted] for finalisation. If agreement will add to consultancy contract to be signed at next meeting.

25/07/06	
ITEM	**ACTION**
Objectives agreed by [redacted] and [redacted] and added to contract which was signed off. Budget • Needs to be finalised for activities: • Costings for promotional materials-leaflets and posters can be printed in house. Confirm costs for wallet cards • Projected costs for both outreach workers £1400 • [redacted] to fund Imam training day • Paan chewing talk Need to follow up PHAs • Media activities – [redacted] will fund Channel S but not Sunrise radio Campaign activities • Promotional - Meeting arranged with [redacted] for 27/07/06 Design of poster complete, needs to be approved by [redacted] and [redacted] and	 [redacted] to confirm [redacted] confirming with the [redacted] Centre [redacted] to contact [redacted] at [redacted] RK to contact PHA line managers [redacted] to confirm costing for Sunrise Radio RK and [redacted] to attend meeting [redacted] to send poster to [redacted] and [redacted]

comms • [redacted] has agreed to conduct the paan chewing talks in the community centre – she will make contact with community centres • Dispensation with council for Health Bus • Media – Channel S confirmed, Sunrise Radio	KZ to contact community centres RK to enquire with council [redacted] contacting Sunrise
Evaluation • Letter to send to level II advisors regarding the campaign needs to be developed and cleared with [redacted] • Evaluation to be discussed further at next meeting	RK to prepare RK to follow up
GANTT chart revised and timetable for activities to be confirmed at next meeting.	

Appendix 4

RAMADAN CAMPAIGN GANTT CHART



Ramadan Campaign Consultancy Project

	2006				
	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER
CAMPAIGN ACTIVITIES					
IMPLEMENT AND REVIEW EVALUATION					

RAMADAN CAMPAIGN ACTIVITIES TIMETABLE

Mosque and Community activities

Date/Time	Activity	Venue	Individuals Involved
13th September 2006 11.00am	Talk For Bangladeshi Females on Paan Chewing	[redacted] Centre	[redacted]
15th September 2006 1.30pm	Imam & Community Outreach Worker Session at Mosque	[redacted] Centre	[redacted]
18th September 2006	Imam's Training Programme	[redacted] Centre	[redacted]
18th September 2.00pm	Talk For Bangladeshi Females on Paan Chewing	[redacted] Centre	[redacted]
22nd September 2006 10.00am – 3.00pm	Health Bus Session	[redacted] Street Market	[redacted]
22nd September 2006 8.00pm	Imam & Community Outreach Worker Session at Mosque	[redacted] Mosque	[redacted]
23rd September 2006 8.00pm	Imam & Community Outreach Worker Session at Mosque	[redacted] Mosque	[redacted]
24th September 2006 8.00pm	Imam & Community Outreach Worker Session at Mosque	[redacted] Cultural Centre	[redacted]
25th September 2006 8.00pm	Imam & Community Outreach Worker Session at Mosque	[redacted] Mosque	[redacted]

26th September 2006 8.00pm	Imam & Community Outreach Worker Session at Mosque	[redacted] Mosque	[redacted]
29th September 2006 10.00am- 3.00pm	Health Bus Session	[redacted] Market	[redacted]
4th October 2006 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers
5th October 2006 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers
7th October 2006 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers
8th October 2006 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers
10th October 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers
12th October 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers
14th October 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers
15th October 10-11am	Mosque Congregation Pharmacy visit	[redacted] Pharmacy	Community Outreach Workers

Media activities

Date	Activity	Venue	Individuals Involved
12th September 2006	Radio jingles and live spot	Sunrise Radio	Community Outreach Workers and [redacted]
14th September 2006	TV Show	Channel S	Community Outreach Workers and [redacted]
19th September 2006	Radio jingles	Sunrise Radio	NA
21st September 2006	TV Show	Channel S	Community Outreach Workers and [redacted]
26th September 2006	Radio jingles	Sunrise Radio	NA
28th September 2006	TV Show	Channel S	Community Outreach Workers and [redacted]
3rd October 2006	Radio jingles	Sunrise Radio	NA
5th October 2006	TV Show	Channel S	Community Outreach Workers and [redacted]
10th October 2006	Radio jingles	Sunrise Radio	NA

Appendix 5

BUDGET

- Community Outreach Workers: £1200 (£600 x2)
- Paan chewing talk: £150
- Imam training: To be funded by the [redacted]
- Promotional materials:
    - Posters: In house printing
    - Leaflets: In house printing
    - Wallet calendar cards: £250
- Media Campaign:
    - Channel S TV shows: To be funded by the [redacted]
    - Sunrise radio shows: £500

Available budget = £3,000

Used budget = £2100

Appendix 6

Client Feedback on Consultancy

Consultant: Riba Kalhar

Project: Ramadan Campaign

Please provide your thoughts on the consultancy process (for example, indicating positive and negative aspects of the process, did the service meet your desired outcome, the conduct of consultant, and recommendations for the future)

Overall I have been very impressed with the consultancy work. The things I found particularly useful were outlining concrete aims and objectives at the start of the process. This made it a lot clearer went the campaign actually commenced as to what needed to be focused on. Having a paper trail of everything made sure that actions were followed up and things got done within the allocated timeframes. It is a difficult campaign to manage because Ramadan takes place for such a long time and all the preparation that needs to take place at the start and also at the end of the campaign. The fact that there are also so many different agencies involved also shows the complexity of working on this campaign.

Measuring all the different outcomes was probably the best part of it all, which obviously helped identify which parts of the campaign are worth pursuing in the future and which ones are not. The fact that we increased referrals so dramatically since the start of the campaign is the biggest indicator of success of the campaign in my eyes. There were positive indicators for all the aims and it's good to be able to objectively illustrate this without just relying on my anecdotal reports, as I did in the past. To me it's really shown how applying an evidence base to your practice, although it takes longer at the beginning, is worth it in the end.

Riba's conduct in the whole process was extremely professional. I think we worked well together as a team. I know I'm not the most organised of individuals and so I found her methodical way of working an adjustment at first, but gradually I think having regular meetings and keeping regular contact over email was good. Overall I feel's Riba's assistance with this project was instrumental in the success of the campaign and I would not hesitate in using her consultancy services again in the future.

PRINT NAME: [redacted] **DATE**: 06/12/06

Appendix 7

POST MOSQUE SESSIONS EVALUATION

1) How useful did you find today's session?

A) Very useful □
B) Slightly useful □
C) Not at all useful □

2) As a result of today's session I have:

A) Increased motivation to quit smoking □
B) Decreased motivation to quit smoking □
C) No change in motivation to quit smoking □

3) As a result of today's session:

A) My knowledge on how to quit smoking has improved a lot □
B) My knowledge on how to quit smoking has improved slightly □
C) My knowledge on how to quit smoking has not improved at all □

4) I will now:

A) Visit Pharmacy for Stop Smoking Support □
B) Visit GP for Stop Smoking Support □
C) Attend Group Stop Smoking Sessions □
D) Call the [redacted] Stop Smoking freephone number □
E) Attempt to quit alone without any NRT/Zyban support □
F) Attempt to quit alone without any behavioural support □
G) Continue smoking □

5) If you will now attempt to quit without any NRT/Zyban or behavioural support could you please explain why?

_____

_____

6) If you will continue smoking could you please state why?

_____

_____

Appendix 8
Pharmacy Ramadan Campaign Evaluation Form

1) Where did they hear about your Stop Smoking Service?

Health Professional		☐		
Poster:	Ramadan Poster	☐	Other Stop Smoking Poster	☐
Leaflet:	Ramadan Leaflet	☐	Other Stop Smoking Leaflet	☐
Card:	Ramadan Card	☐	Other Stop Smoking Card	☐
Ramadan Mosque Sessions		☐		
Ramadan Health Bus		☐		
Ramadan Community Centre Talks		☐		

Other: (please specify) …….

2) For those who heard of your service as a result of the Ramadan campaign what was the outcome?

They made an appointment ☐

They bought NRT products ☐

You referred them elsewhere (please specify)…….

Other (please specify).....

3) For those who made an appointment with you, did they attend?

Yes ☐

No ☐

Appendix 9

Ramadan Campaign 2006
Clients appointments with pharmacy after mosque talks

Date	Client's Name	DOB	Address/P Code/ Tel	Pharmacy/ Pharmacist	Date & time of 1st appointment	Arranged by

Appendix 10

RAMADAN CAMPAIGN 2006 REPORT

CONTENTS PAGE

1. Summary

- The 2006 Ramadan Campaign in [redacted] was a fixed term project developed in partnership with [redacted] PCT, the [redacted] local mosques and voluntary organisations, focusing primarily on the Bangladeshi population in [redacted].
- The campaign consisted of mosque activities, media activities, other community activities and the use of promotional material with the aim to raise awareness of the harmful effects of smoking and to also increase the number of Bangladeshi people accessing [redacted] Stop Smoking Services.
- A total of 249 people from 6 local mosques attended stop smoking talks run by 2 Bangladeshi Community Outreach Workers. The vast majority of the 249 people found the talks to be very useful with only 13 (5%) stating they wanted to continue smoking by the end of the session. 184 (74%) expressed the desire to visit a pharmacist.
- In total 56 people from the stop smoking talks went on to make a first appointment with [redacted] Pharmacy, who provided stop smoking support in liaison with the Community Outreach Workers.
- 48 (86%) attended the first session and set a quit date. Of the 48 clients who set a quit date, 26 (54%) quit smoking and 7 (15%) did not. 15 clients (31%) were lost to follow up. This is the highest number of referrals and quitters [redacted] Stop Smoking Service has received from its Ramadan Campaigns to date (there were only 3 referrals from the 2004 campaign).
- The media campaign involving national radio and TV shows did not prove to be as successful with no referrals being made to [redacted] Stop Smoking Service.
- The health bus, which was in [redacted] Market for 2 days, resulted in 6 referrals to the Stop Smoking Service. Unfortunately rain on both days kept the crowds away. The community centre talks resulted in 9 referrals to the Service.
- Recommendations to aid future campaigns include: i) to have a Bengali speaking level II advisor based with [redacted], ii) set up a steering group with representatives from, for e.g. [redacted], [redacted] PCT Health Promotion Team, [redacted] Pharmacy, Voluntary organisations, iii) have greater community based activities to access a wider section of the community, iv) target the Somali population, v) commence the campaign one

month prior to the start of Ramadan and vi) research into effective smoking cessation support for South Asian and Black African groups.

2. The Ramadan Campaign

The Ramadan Campaign was originally developed by Tower Hamlets Health Strategy Group in the 1980s and as a result of its success has subsequently been taken up by national, regional and local agencies.

The month of Ramadan is a time when Muslim people give priority to their spirituality and become more aware of their physical and mental health and wellbeing. This involves fasting from dusk to dawn, and disengaging from activities that are detrimental to one's health and conflict with the teachings of the Quran.

Hence Ramadan is considered an ideal time to raise awareness of the harmful effects of smoking and promote the stop smoking support services available to the Muslim community.

3. Summary of Past Ramadan Campaigns

In previous campaigns [redacted] PCT has worked on [redacted] campaigns and joint campaigns with [redacted] PCT. The campaigns in the last two years have been successful in promoting information about the importance of tobacco cessation and the support services available. However, the number of people who translate this interest and information into action to access stop smoking support is very low.

4. Aim of 2006 Ramadan Campaign

The aims of the 2006 campaign were to promote the harmful effects of smoking and stop smoking support services available to the Muslim population of [redacted] and to also increase the number of Bangladeshi men accessing [redacted] Stop Smoking Services. The campaign was conducted by [redacted] PCT Stop Smoking Service and the Health Promotion Team.

5. Focus Population for 2006 Ramadan Campaign

The primary focus of the 2006 Ramadan Campaign was the Bangladeshi population because they represent the largest BME group in [redacted] which practices the Muslim religion.

The 2001 Census indicates that 40% of the population is from black and minority ethnic (BME) groups, with many being from routine and manual groups. The largest BME groups in [redacted] are Bangladeshi (6.4%) and Black African (6%). In terms of religion, 47% of [redacted] people describe themselves as Christian, 12% Muslim, and 6% Jewish (National Census 2001). The majority of the 12% of Muslims comprise of the Bangladeshi, Black African and Turkish population of [redacted]

The [redacted], [redacted] and [redacted] districts of [redacted], in particular, have a high proportion of Bangladeshi people. Health profiles of these areas indicate that super output areas (SOAs) within the wards of [redacted] and [redacted] are among the 20% most deprived SOAs in England.

6. Campaign Activities

i) Mosque Activities

The main focus of the 2006 Ramadan Campaign was centred on mosques in [redacted] with a predominantly Bangladeshi congregation. The mosques were targeted because they provide a

convenient way of accessing large numbers of the community for health promotion activities. Generally Muslims who may not visit mosques on a regular basis try to attend during the month of Ramadan. They spend a great deal of time in the mosque, praying and socializing, which provides an ideal location to access them. The support and presence of religious leaders also lends credibility to the activities and gives encouragement to people adopting healthier lifestyles.

In total 6 mosques were targeted:

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]

In an attempt to increase the number of people accessing stop smoking support, 2 Bangladeshi community outreach workers were employed and level II trained. Their role was to assist with the campaign from the initial stop smoking promotion stages, right through to actively supporting people to quit smoking by working in liaison with level II advisors from [redacted] Pharmacy.

The mosque activities included:

- Providing refresher level I training for the Imams. This was conducted by [redacted] from [redacted] PCT Stop Smoking Service. The training formed part of a wider event run in conjunction with the [redacted] which was aimed at helping Imams to promote health within the community. The event was opened by [redacted]

- Sermons were delivered by the Imams during Friday prayers over the whole month of Ramadan on the importance of stopping smoking. Interested members of the congregation were invited to attend special stop smoking talks which were held in the mosques.

- Stop smoking talks were conducted by the community outreach workers in the mosques to promote the stop smoking message and gave further details on how to quit smoking and access the support services available in [redacted], for e.g. 1:1 support from Bangladeshi speaking pharmacists in the area.

- Appointments for stop smoking support were made for those people who felt ready to quit after the stop smoking talks held in the mosques. These appointments were made with the community outreach workers who worked in liaison with level II advisors from [redacted] pharmacy. Support was provided both within the pharmacy and the client's home depending on the client's preference.

ii) Media Activities

A media campaign consisting of TV and radio shows was carried out:

- 3 live TV programs on Channel S (national Bangladeshi satellite channel) were conducted. The community outreach workers along with a member of [redacted] PCT health promotion team were invited to a studio discussion show where they promoted the harmful effects of smoking and the importance of giving up along with ways to quit smoking and the support services available. They publicised the national and local [redacted] Stop Smoking freephone number.

- One of the community outreach workers along with a member of the [redacted] PCT health promotion team carried out 6 live programmes on Sunrise radio (national Asian radio station). Again they promoted the harmful effects of smoking and the importance of giving up along with ways to quit smoking and the support services available.

iii) Other Community Activities

Health Bus

The Health bus was parked in [redacted] Market between 10.00am-3.00pm on two days over the Ramadan period. [redacted] Market is situated in the [redacted] district of [redacted] and attracts a large Bangladeshi crowd. The bus was manned by two health trainers and one community outreach worker, who provided stop smoking advice and promotional material for the Stop Smoking Service to interested members of the public. The details of those people who wished to be referred to the service were collected.

Community Centre Talks on Chewing Tobacco for Bangladeshi Females

Although the numbers of Bangladeshi females that smoke is very low compared to males, they have a higher rate of chewing tobacco. Special talks were arranged for Bangladeshi females in the community highlighting the harmful effects of chewing tobacco. These took place in the [redacted] and [redacted] by a member of the [redacted] PCT health promotion team.

iv) Promotional Material

- A3 sized multilingual posters were created highlighting the message that Ramadan is an ideal time to quit smoking. These were distributed to local pharmacies, GP practices, mosques and community centres.

- Pocket-sized cards which contained a calendar of significant Muslim religious events alongside details of the local stop smoking support service were developed. These were distributed in mosques and local community centres.

- An A5 sized leaflet which provided details of the stop smoking talks in the mosques and information on the stop smoking support provided by the outreach workers in liaison with [redacted] pharmacy was developed. This also contained contact information of the

pharmacies which offer stop smoking support in Bengali and Urdu alongside English. These leaflets were distributed in the local community.

7. Results of Campaign Activities

i) Mosque Activities

Imam Sermons and Mosque Stop Smoking Talks

The table below highlights the average number of people in each mosque, who heard the sermons by the Imams on the importance of giving up smoking, which were delivered during Friday prayers over the whole month of Ramadan.

The table also shows the number of people who after hearing this sermon then attended the special stop smoking talks provided by the community outreach workers at the mosques.

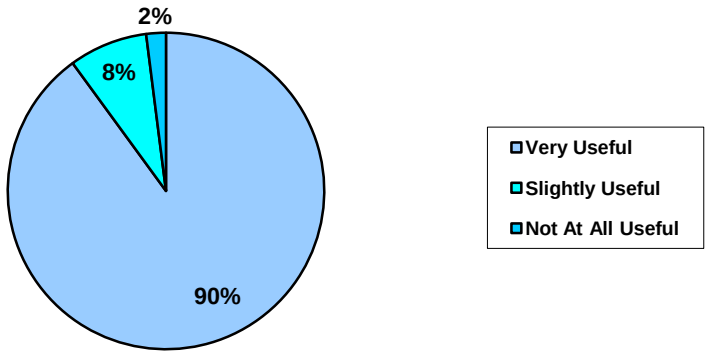
Mosque	**Number of People Attending Friday Prayers**	**Number of People Attending Stop Smoking Talk in Mosque**
[redacted]	369	46
[redacted]	167	26
[redacted]	151	45
[redacted]	122	36
[redacted]	443	57
[redacted]	355	39
	Total- 1607	**Total- 249**

It can be seen that from the original 1607 people who were informed of the stop smoking talks, a total of 249 people (15%) actually attended the talks held at the mosques.

The 249 individuals who attended the talks were asked to complete a questionnaire to evaluate the stop smoking talks. The results are outlined below:

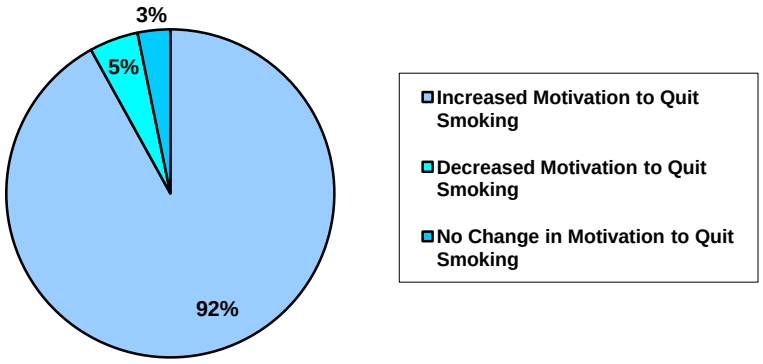
Ramadan Campaign Consultancy Project

1. How useful did you find today's session?



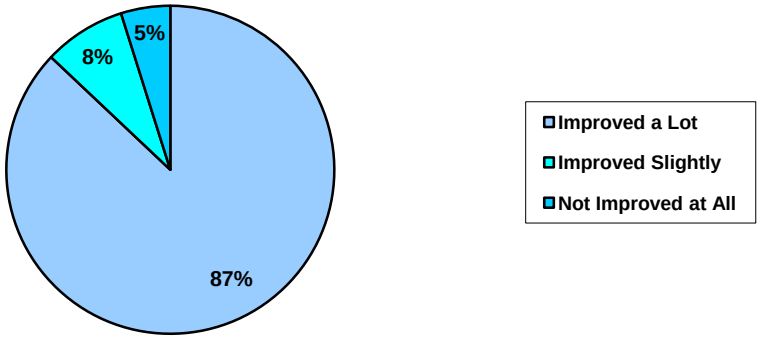
It can be seen that the vast majority of the 249 respondents (90%) found the session very useful.

2. As a result of today's session I have:



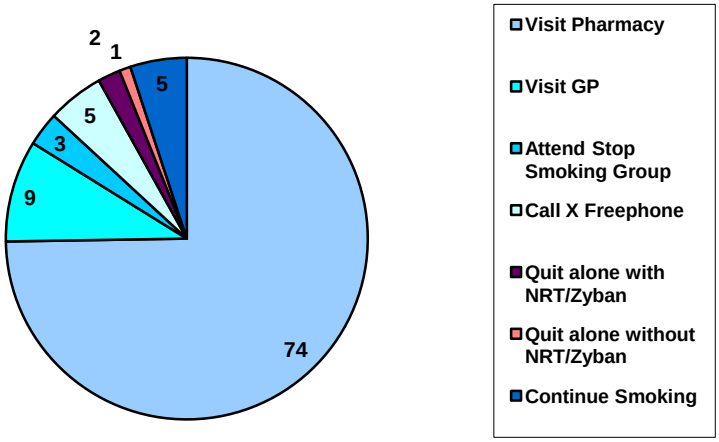
It is apparent that the vast majority of the 249 respondents (92%) had increased motivation to quit smoking as a result of the session.

3. As a result of today's session my knowledge on how to quit smoking has:



247 of the 249 respondents answered this question. Of the 247 it is evident that the majority (87%) felt that their knowledge on how to quit smoking had improved a lot. Only 5% felt it had not improved at all.

4. I will now:



It can be seen that the majority of the 249 respondents (74%) had a preference for visiting the pharmacy for stop smoking support. 5% expressed a desire to do nothing and continue smoking.

5. If you will now attempt to quit without any NRT/Zyban or behavioural support can you please explain why?

Reason	Number of Respondents
No time to attend GP/Pharmacy	1
Don't like medication	1

Only 2 respondents provided reasons for why they were going to quit without any NRT/Zyban or behavioural support, stating a lack of time and dislike of medication.

6. If you will continue smoking can you please state why?

Reason	Number of Respondents
Enjoy smoking too much	2

Out of the 13 smokers who stated they would continue smoking only 2 (15%) provided reasons, citing their enjoyment of smoking.

Stop Smoking Support Program with Community Outreach Workers in Liaison with [redacted] Pharmacy

During the stop smoking talks in the mosques 184 of the 249 respondents (74%) had expressed that they would visit a pharmacist to help them quit smoking. Of these 184, 56 (30%) accepted the invitation to make a first appointment with [redacted] Pharmacy in liaison with the community outreach workers.

Of the 56 individuals who made an initial appointment with [redacted] Pharmacy in liaison with the community outreach workers 48 (86%) attended the first session and set a quit date. The following table highlights the progress of these 48 individuals through the 5-week program.

Stage of Stop Smoking Program	Number of Clients	Percentage of Clients
Number of Clients Who Set a Quit Date	48	100
Number of Clients Who Attended the Quit Date	40	83
Number of Clients Quitting	26	54

Number of Clients Not Quitting	7	15
Number of Clients Lost to Follow Up	15	31

It can be seen that of the 48 clients who set a quit date, over half (26, 54%) quit smoking. 15% did not quit and about a third (31%) were lost to follow-up.

ii) Media Activities

There were no calls to the local [redacted] Stop Smoking freephone number from clients stating the Bangladeshi TV channel or radio station as the source from which they heard of the service.

iii) Other Community Activities

Health Bus Referrals

In total 6 Bangladeshi individuals who visited the health bus were referred to [redacted] Stop Smoking Service. Unfortunately the rainy weather on both days reduced the number of people visiting the market.

Community Centre Talks on Chewing Tobacco for Bangladeshi females

10 women attended the [redacted] Centre talk. 4 of them wanted to give up smoking and were referred to the local pharmacy. 12 women attended the [redacted] Centre talk, of which 5 were referred to the local pharmacy.

8. Recommendations

The 2006 Ramadan campaign was successful in terms of raising awareness of the harmful effects of smoking and increasing the number of Bangladeshi people accessing stop smoking support compared to previous year's campaigns. However, to improve upon this year's efforts the following is recommended.

- The 2006 Campaign demonstrated that there is a wide interest in the Bangladeshi community to give up smoking. In regards to stopping smoking, people mainly expressed a desire to visit pharmacies in [redacted] for support. This was because it was the only service which had Bengali speaking advisors, which highlights the importance of having level II Bengali-speaking advisors in the Stop Smoking Service.

- Although individuals expressed the intention to visit the pharmacies when it came to actually making appointments and remaining on the whole 5 week programme individuals preferred the level II support offered by the community outreach workers. The use of Bangladeshi community outreach workers was effective in building relationships between the community and the Stop Smoking Services which allowed the Bangladeshi population to feel more at ease and comfortable in accessing stop smoking support. Also the flexibility provided by the outreach workers by visiting clients in the home and other bases in the community at all times of the day was also advantageous. Hence having community-based advisors appears to be beneficial.
- Localised community based activities were more effective in increasing Stop Smoking Service uptake as opposed to national media based activities, which should be the focus for future campaigns.
- Although the mosque sessions reached large numbers of the community, future campaigns should have a greater range of activities in a range of locations to reach wider sections of the community including, for e.g. the youth. This will involve greater partnership working with other services in the area, for e.g. the voluntary sector and SureStart, which can be aided with the development of a steering group.
- Although the focus for this year's campaign was the Bangladeshi population, because the Somali population is also increasing in [redacted] this group should also be a focus group for future campaigns.
- As opposed to focusing the campaign during the period of Ramadan the campaign should commence at least a month before the start of Ramadan. This allows people to have some preparation time to quit smoking by the time Ramadan starts. Therefore development of the 2007 Campaign should commence in June 2007 to allow enough time for the correct processes to be in place.
- In order to develop effective Stop Smoking Services, data into effective smoking cessation support for South Asian and Black African populations needs to be investigated and research conducted. Successful quitters from these groups could also be followed-up to examine what enabled them to be successful and for possible outreach work.

SECTION C

PROFESSIONAL PRACTICE

IMPLEMENT INTERVENTION TO CHANGE HEALTH-RELATED BEHAVIOUR

COMPETENCE

Conducting a Rolling Format Stop Smoking Group

IMPLEMENT INTERVENTION TO CHANGE HEALTH-RELATED BEHAVIOUR COMPETENCE: CONDUCTING A ROLLING FORMAT STOP SMOKING GROUP

1. Setting up of intervention

The health-related behaviour to be changed was the smoking behaviour of clients in a deprived inner city borough and the intervention implemented was the use of National Health Service (NHS) level III Stop Smoking Support. Level III stop smoking support involves receiving support in a group setting delivered by a Specialist Stop Smoking Advisor. This case study will focus on the experience of one client called Bob who attended the group service.

Level III stop smoking support is based on the Maudsley model (Hajek, 1989), which is recommended for NHS services. This model is considered to represent the gold standard for evidence-based practice (Raw et al., 1999, West et al., 2000) comprising of structured withdrawal oriented behavioural group therapy utilising stop smoking medication, such as Nicotine Replacement Therapy (NRT) or bupropion (for up to 12 weeks). The intervention is based on a complete abstinence approach consisting of a 6 -12 week programme. In our service the programme is for seven weeks with the first two weeks being preparation sessions for quitting, week three being the quit day and the remaining four weeks consisting of ongoing support and monitoring. In accordance with Department of Health requirements, a client is regarded a successful quitter if they do not smoke for at least the last two weeks of a four week period after their quit date, which is physiologically verified with a Carbon Monoxide (CO) machine reading (Department of Health , 2009).

In order to provide level III stop smoking support, I had to attend a three-day level III training programme, which covered all elements of the Maudsley model and also shadowed trained colleagues in the service. The Maudsley Model draws mainly upon two approaches to behaviour change, the Stages of Change Model (Prochaska & Diclemente, 1983) and Motivational Interviewing (Miller & Rollnick, 1991). So for example, there is a preparation session involved in the programme, which involves planning for the quit attempt in line with the preparation stage of the Stages of Change Model and also the client's motivation is regarded as key, with the advisor's role to nurture the client's motivation and confidence through collaborative working. Also, being a specialist advisor, I was allowed to provide prescriptions for stop smoking medication by writing a 'letter of recommendation' to pharmacists (for Nicotine Replacement Therapy) and General Practitioners (for buproprion) (appendix 1).

Traditionally group stop smoking support has comprised of a closed group format which involves all members starting and completing the programme at the same time (National Institute for Health and Clinical Excellence, 2008). This case study will focus on our service's trial revision of this format consisting of an open rolling group format. With this format instead of having the usual set seven week programme where all the smokers join and quit on the same day, new people can attend the group every week. Hence at any given week, members could be at varying stages of their quit attempt. Due to current insufficient evidence on rolling groups because it is a relatively new format, The Department of Health (2009) recommend the use of rolling groups in services as a small-scale pilot initially, to assess its effectiveness, before being adopted as a significant part of the service (Department of Health, 2009). The main reason for trialling this approach in our service was for practical reasons, primarily because there were not many people accessing group services and they would have to wait for up to seven weeks for a

new group session (as the duration of one programme to be completed was seven weeks). This was encouraging people to use one-to-one services instead. Also this new group format was to act as a relapse prevention group, whereby past quitters could attend the session at any time for relapse prevention support. Research into other localities similar to ours, which have trialled the new format, identified that they had also used it to aid with relapse prevention and that advantages included less waiting time for new members and also that group members who were doing well in their quit attempts helped boost the confidence of new members.

The group was to take place for an hour in a private room (as recommended by West et al., 2000) at a local health centre, where it had been running for a number of years. The room was large enough to accommodate up to 30 people, as recommended by West et al. (2000), with good disabled access from the main reception, and with comfortable seating and good lighting (Jacobs et al., 2009). The groups run by our service currently had approximately a maximum of 10 people attending. The health centre is located in an area of high deprivation in an attempt to encourage and support more routine and manual workers to stop smoking, in order to help reduce health inequalities as recommended by the Department of Health (2009). To aid accessibility the health centre is in a central convenient location with good transport links and clients are able to self refer via the service freephone or be referred by health professionals.

There were extra preparations that needed to be conducted with the implementation of the rolling group format. Firstly, there was more paperwork required because group members would be at different stages of the quitting process, hence requiring different handouts and leaflets applicable to their current stage. Also the group was divided into two main sections, with the first 15 minutes allocated to new arrivals and the remaining 45 minutes to the whole group discussion. Research from other localities had shown that during the first 15 minutes, older group

members were happy to talk among themselves and were also happy to assist in settling the new arrivals, which aided with group bonding.

1.1.Reflection

After previously running the stop smoking group according to the set seven week format I was slightly apprehensive about delivering the rolling group. This is because it was a new venture by the service and there was little guidance on implementing it. Also because I realised that group cohesion has such an important impact on the effectiveness of the intervention, I was worried about how relations between group members in the rolling group would develop, given the inter-changeability of group members every week. However, researching thoroughly with localities similar to ours who had trialled the intervention helped to alleviate this apprehension and as a result of the positive outcomes they described, especially with regards to the positive quit experiences helping to build confidence in new members, I was quite excited about trialling the new format.

When conducting level III stop smoking support or any stop smoking support in the service I knew my role was to help as many individuals become successful 4 week quitters (in accordance with the Department of Health definition of a successful quitter, discussed earlier) to help our service meet its annual quitter targets, set by the Department of Health. However, I did not let this target consume me too much, although I was mindful of it. Through reflecting on my own current experience of providing stop smoking support and also on the experiences of my colleagues I had realised that some clients, particularly those from complex client groups such as pregnant women and those with mental health problems, took a longer time to reach abstinence

than the four week period permitted by the Department of Health. If they took a longer time to reach abstinence I did not deem this an 'unsuccessful quit attempt' although it was with regards to the Department of Health's definition of a successful quitter. Therefore I did feel there were conflicts between my own personal definition of a successful quitter and the definition I had to officially work against. Also I did not just want to go in with the mind-set of trying to get the client to quit for four weeks to help meet service targets. I wanted to go in with the intention of helping them to stop smoking long-term.

Knowing that the Maudsley Model had a strong evidence base behind it helped increase my belief in the intervention and so I felt more confident about implementing it. Initially however I did experience a personal struggle about advocating an intervention which consisted of the use of medication as first line treatment, mainly due to my cynicism of the pharmaceutical industry. However, these concerns were appeased when I understood the physiological nature of smoking addiction. Also because the psychological elements of smoking as an addiction were being addressed alongside the physiological elements, I also felt more comfortable about delivering the intervention. Due to my health psychological background I was already familiar with the theoretical basis of the intervention and the psychological strategies involved in the intervention, such as the use of Motivational Interviewing techniques, and this helped in my confidence to deliver the intervention.

2. Implementation of intervention

2.1.Session 1 - Preparation week

The week that Bob joined the rolling group there were no other new members that were expected to the session. The group currently consisted of five other members; Steve, Janita, Max, Louise and Terry. Steve was the newest member of the group, having joined the group for one week and Janita the oldest member, having been at the group for six weeks (see appendix 2 for the group members' ages and details of their quit attempt when Bob joined).

I was provided with basic details about Bob (which are recorded for all new referrals) from the Assistant Psychologist who deals with new referrals in the service. This consisted of basic demographic information, current smoking behaviour, current health conditions and details of past quit attempts (appendix 3). Bob was a 65 year old gentleman who had been smoking for 50 years. He was currently smoking 40 cigarettes a day and had made one previous serious quit attempt by himself where he only managed to quit for 1 day. With regards to health conditions he had arthritis and asthma. Bob had self-referred himself by calling the service freephone. He had been provided with information on how the group ran by the Assistant Psychologist along with details on the location and instructions to arrive early, as the first part of the session was allocated to dealing with new members.

I always arrived at least 20 minutes prior to the start time of the group in order to set up the room and organise my materials. This involved organising the seating and having all the paperwork and materials, such as prescription pads and the Carbon Monoxide machine ready. The seating was arranged in a circular formation to i) encourage participation, communication and involvement from the group members ii) create an informal atmosphere and iii) to help place me as the advisor on all equal level with the group members (Jacobs et al., 2009; Pont, 2003).

Conducting a Rolling Format Stop Smoking Group

When a new client first arrives to the group it can be quite a nerve-wracking experience, especially in a rolling group when the other group members are already familiar with each other. As a positive group dynamic and bond is an instrumental element in the effectiveness of the intervention (Hajek, 1994), when Bob arrived I tried to put him at ease with a welcoming smile and after I introduced myself I introduced him to the other group members. The other group members immediately drew him into their conversations by filling him in on their quit attempts, etc.

While the other group members completed their monitoring forms, which were used to log weekly smoking status, firstly I commended Bob for the first step he had taken to quit smoking as it can be a daunting prospect for smokers (Shields, 2005). I explained to him that the first session was a preparation session and outlined the content and structure of the programme (which is also mentioned by the Assistant Psychologist when initially contacting referrals). I also explored his expectations regarding the programme to ensure there was consensus. He said he was ready to stop smoking completely and wanted assistance and agreed to commit to the abstinence approach of the programme and to attend weekly for the seven week duration of the programme. I also checked that he was not seeking stop smoking support from another NHS service. He was then asked to complete a monitoring form (appendix 4). The monitoring form captured demographic data, details of current smoking behaviour, health conditions and also a consent section which clients sign to agree to take part in the programme and for their data to be stored on the service's central database. The monitoring form also included a weekly log of sessions, which clients completed every week and also a weekly log of withdrawal symptoms to allow clients to monitor their nicotine withdrawal symptoms as the programme progressed. Bob then joined the rest of the group members.

I explained the importance of the preparation session to Bob and invited him to share his motivation for wanting to stop smoking with the rest of the group, along with his pros and cons for quitting. This is because as Rollnick et al. (1999) state, cost-benefit analysis can assist with deciding to change and also I wanted to gauge whether he was at the group out of personal choice (as opposed to pressure from a doctor, relative, etc), because as Rollnick and Miller (1995) state, it is important that motivation to change comes from the client and is not imposed by external sources. Bob cited concerns over his future health, wishing to see his grandchildren grow up and financial cost as main reasons for quitting smoking and his pros heavily outweighed the cons. He agreed to have one week preparation time and to set his quit date for the following week.

The client's confidence levels are also addressed in the first session as well as in the forthcoming sessions, because as Bandura (1997), states confidence in the form of self-efficacy can be a crucial element of behaviour change. Bob was asked to rate his confidence on a scale of one to ten (one indicating low confidence and ten high confidence) to get a confidence score, which is recommended by Rollnick et al. (1999). Bob rated his confidence as a five. I attempted to increase this confidence because, as Schwarzer and Fuchs (1995) state, high levels of confidence make it more likely for individuals to achieve their goals and overcome obstacles (Schwarzer & Fuchs, 1995). This was done through attempts at problem-solving, by exploring Bob's previous quit attempt, which I and the other group members participated in. For example, when Bob spoke about the difficulties he had experienced with his past quit attempt when he had attempted to go 'cold turkey' by not using any medication or receiving support from the NHS, the other group members who had already commenced their quit attempts related with his experience as they all had attempted to go 'cold turkey' in the past. They then outlined the

differences they had experienced with this quit attempt and mentioned how the use of medication had really assisted with their withdrawal symptoms. Also because Janita who was the most advanced in the group (having been quit for three weeks), used to smoke a similar amount of cigarettes to Bob, hearing about her experience really seemed to boost his confidence and strengthen his faith in the treatment. He ended up choosing the same products as her, which were the inhalator and the patch, for which I provided a prescription.

In an attempt to encourage discussion between the group members, I would look to the other members when somebody spoke directly to me in an effort to invite their participation. This would then encourage dialogue between the group members. A major part of the group intervention involves alternating between the roles of information-giver and group facilitator for discussion, and it was important to try and get the balance right so that the session did not involve me talking all the time. When it came to providing factual information, for example, on how the programme worked, information on health effects of smoking or how to use the different NRT products, I would talk more. Or when somebody provided incorrect information or wandered off topic I would need to intercept to ensure there was enough time for all relevant matters to be covered before the session finished. However, otherwise I let the group take over.

At the end of the first session Bob was provided with handouts to assist with his preparation for quitting. These included a diary to monitor smoking behaviour (appendix 5), a smoking ‘pros and cons’ sheet (appendix 6), suggestions on behavioural coping strategies (appendix 7) and a booklet on stopping smoking. Also all group members were invited to state a commitment at the end of the session, which outlined a mini goal they had for the week. The purpose of this was to encourage self-monitoring (Bandura, 1998). Bandura (1998) argues that setting mini goals is important because their achievement can improve self-efficacy and

perceived levels of behavioural control. Bob stated his mini goal was to explore triggers to his smoking behaviour in order to develop appropriate coping strategies. A Carbon Monoxide (CO) reading was also taken every week, the purpose of which was to provide a physiological validation of smoking status every week and also to boost motivation when clients see their CO levels falling after quitting (Raw et al., 1998). A reading of less than 10 parts per million (ppm) indicates a non-smoker's level and 10ppm and above, a smoker's level (Department of Health, 2009). Bob got a CO reading of 25ppm his first week, which he got worried by. It was important that Bob was aware of the dangers posed to his health as a result of high carbon monoxide exposure, because as Young et al. (2010) state, smokers can sometimes have an optimistic bias regarding their susceptibility to smoking related illness and it is important they gain an understanding of the risks and severity of smoking in order for them to become motivated to quit. However, I also reassured Bob by emphasising that the carbon monoxide levels drop very quickly once you quit smoking. Bob commented that this had made him more determined to quit smoking, which was a positive thing.

2.2.Session 2 - Quit week

In the second week, which was Bob's quit date, I checked back on his motivation to quit just in case things had changed since the first week and asked him to discuss his feelings about quitting. He said he had been thinking about the quitting process all week and was even more determined about quitting. He had had his last cigarette when he had woken up and had given the remainder of his cigarette packet to his neighbour so he did not have any cigarettes supplies on

him. Removal of cigarettes is encouraged as there is then less temptation to smoke. I checked his confidence level, which he reported as a 7, which was an improvement on the previous week. He was asked to talk about the coping strategies he had developed over his preparation week. These included doing gardening, which he had been putting off for a long time, as a way to deal with the increased amount of free time he would have on his hands from quitting smoking. Another strategy for him was to put a press cutting on his fridge about a lady's battle with cancer, caused by a lifetime of smoking, which had great emotional impact on him and he would look at if he experienced a craving to smoke. By asking clients to develop their own coping strategies the idea was that they would have more ownership over them, which is considered to help clients sustain behaviour change (Walsh et al., 2004). Also the use of rewards (Skinner, 1969) was encouraged to help implement these strategies and reinforce motivation, as quitting smoking can be a negative experience particularly in the early stages when withdrawal symptoms are at their peak (Brown et al., 2005). Bob spoke about how he would like to save the money he saved from smoking and use it to treat himself. Checks on Bob's medication supplies and directions on use were also reiterated, which was aided by the other group members who gave advice on use. For example, Janita demonstrated how she used her inhalator. Bob's Carbon Monoxide reading was taken again and although it is not suggested to clients to cut down during their preparation week, Bob had reduced his intake from 40 to 20 cigarettes as a result of being very conscious about each cigarette he smoked. This was reflected in his reduced CO reading which was 18ppm. Although this still reflected a smoker's level this reduction was motivating for Bob. At the end of the session Bob's commitment for the week was to take quitting 'a day at a time'. This is often stated by clients because thinking about quitting longer-term can be quite daunting in the early stages. He was also provided with a handout giving information on 'the first week without

smoking' (appendix 8), which provided information on withdrawal symptoms and the importance of using the stop smoking medication regularly.

2.3.Session 3 - 1 week post quit week

After the first week Bob did not manage abstinence but had cut down from his 20 cigarettes a day (from the previous week) to 6 a day. I asked him how he felt about this and he said he felt happy he had cut down but disappointed in himself that he did not reach abstinence as that had been his goal. He indicated that he was still committed to abstinence and determined to quit smoking. Firstly, I praised him for having cut down because discouragement at this early stage could potentially dishearten the client, leading them to abandon their quit attempt (Zimmerman et al., 2000). Next, I enquired about his use of NRT, as under-use of NRT is recognised as one of the main reasons for relapse (Foulds et al., 2009) and then explored the triggers for his cigarettes to identify if there were commonalities. The aim was to then set goals to prevent recurrence. Lack of NRT usage was identified, so one goal for the week was to increase usage to the recommended dosage. Also the pub situation was identified as encouraging relapse due to friends smoking outside and offering cigarettes. Therefore Bob said he wanted to avoid going to the pub for the first few weeks when the withdrawal symptoms would be at their peak. A check on Bob's confidence level revealed it had dropped from the previous week to a 5. The group provided encouragement to Bob. Also as his CO reading had dropped from the previous week to 14ppm this was also encouraging for him. At the end of the session he was provided with a handout on dealing with a lapse (appendix 9).

2.4.Session 4- 2 weeks post quit week

Unfortunately the following week Bob had continued to smoke 6 cigarettes a day and had not carried out his goals for the week (i.e. not increased NRT usage or avoided going to the pub). This is when the group dynamic can have a negative impact on a client's quit attempt as well as a positive one because Bob had forged a good bond with fellow group member Steve who was having trouble cutting out his last two cigarettes. Both were of similar ages, from a naval background and with similar smoking experiences. Steve had been sick for a couple of weeks with flu which had delayed his quit attempt and had returned when Bob had joined the programme. Both of them had expressed commitment to abstinence, set goals, but then failed to carry out their goals in the last week. I brought this inconsistency to their attention. Bob admitted his goals were achievable and that he had not exercised enough willpower over the week. He apologised to the group and said he would make a concerted effort this week. It was also identified that part of this resistance was due to not wanting to offend his friends by not going to the pub with them. The other groups members empathised with this and offered advice. Bob concluded that if they were his good friends they would understand his actions. Steve on the other hand, stated that although he thought he had been ready for abstinence, which he had been saying every week he attended the group, over the last week he realised he was happy with just having cut down and would return to the group when he felt fully committed to being abstinent. This was despite my advice to the group that the cutting down was not as effective as the abrupt cessation approach (Wang et al., 2008).

2.5.Session 5 (3 weeks post quit week) – End of programme

The following week Bob returned to the group and had managed to stick to his goals and had remained abstinent. He got a CO reading of 1ppm and reported his confidence had really increased (confidence level of 8) due to having achieved one week abstinence. He went on to remain abstinent the following week and became a successful 4 week quitter (as he had remained abstinent for the last two weeks of his 4 week quit attempt). During this time the use of rewards was an effective strategy in helping to sustain the non-smoking behaviour, as he would treat himself to special gifts with the money he was saving from stopping smoking. Also improvements in his breathing, sense of taste and smell motivated him. He was presented with handouts every week to help sustain the non-smoking behaviour, including handouts on shorter-term relapse prevention (appendix 10) and longer-term relapse prevention strategies (appendix 11). Also Bob was presented with a certificate for quitting (appendix 12), which he was very proud to receive. As the group was a rolling group format and also served as a relapse prevention group Bob did not have to leave the group seven weeks after joining which he was very pleased about as he felt he wanted a few extra sessions to help build his confidence and to assist with relapse prevention. He returned for an additional three weeks before leaving the group (refer to appendix 13 for a log of all of Bob's sessions).

2.6.Reflection

Conducting a Rolling Format Stop Smoking Group

I found it more difficult to prepare both practically and mentally for a rolling group than the set group. As clients were at varying stages of their quit attempt and new group members could attend during any given week I had to ensure I had all relevant paperwork for all stages of the group programme at hand. This meant having to carry a greater amount of materials with me. Also mentally I had to be flexible in dealing with very different questions from the clients depending on what stage of the programme they were at. Having to be constantly alert to different questions was a pressurising experience. This did get easier with time and practice but was still more challenging than doing the closed group. Also I felt I was able to deliver the intervention effectively with the small group numbers but if numbers had increased to over 10 in the group this would have proved more challenging. This is because it takes a greater length of time to work with clients in the rolling group format (mainly due to new comers) and so having a great increase in group numbers would make the session longer than the allotted one hour period or require another member of staff to assist.

Although from a practical point of the view the rolling group may have been more difficult to implement I did notice the advantages from a therapeutic point of view. For example, having group members present who had already quit really helped with Bob's confidence when he first joined the group. It was also good to see the older group members assist with the usage of medication and offer helpful tips, almost like becoming mentors, which helped to develop the group bond. Also it was good that Bob had the flexibility to stay longer than the set seven week programme, which he found helpful in regards to building his confidence over relapse prevention.

There were also challenges experienced from a therapeutic point of view. When Bob and Steve did not fulfil their goals for the second week I found it challenging questioning them about

this. I had reflected on my practice and wondered whether I had managed to get balance right in earlier weeks between giving enough praise for having managed to cut down yet not having reinforced the cutting down approach and not abstinence. Although I do not like confrontation I realised I had to contest their inconsistency in demonstrating commitment to the programme (by setting goals and then not implementing them) if they were going to progress in the programme. This process was made more difficult because there were a couple of newcomers to the group that week, who were not fully aware of the incidents leading to this situation, and I did not want them to think I was being unnecessarily harsh. However, I also considered it was not fair on the other group members to provide support to individuals who were not showing the same levels of commitment they were.

Throughout the intervention I had to constantly re-evaluate and help Bob implement new strategies to assist with abstinence, dependent on his progress. I found this to be quite a creative process and enjoyed the collaborative working between Bob, myself and the other group members.

3. Evaluation of the intervention

The intervention was evaluated using both standardised objective methods and also more subjective ones.

The main objective method of evaluation is the Department of Health performance indicator for NHS Stop Smoking Services, consisting of self-reported non-smoking status four weeks after the quit date, which can be physiologically verified with a Carbon Monoxide reading

(Department of Health, 2009). If the client has not smoked at all between two and four weeks after setting the quit date they are considered a successful quitter for the service. The fact that the "last two weeks of the quit date" measure is included is because it is predictive of long-term abstinence and allows a period of grace in recognition of the fact that some smokers initially struggle but then manage to quit (West, 2004). Bob did not remain abstinent for the full four weeks after his quit attempt but did remain abstinent for the last two weeks of these and therefore was regarded as a successful quitter. His Carbon Monoxide readings validated his self-reported smoking status. When he initially came to the group he had a reading of 25ppm which was indicative of a heavy smoker and his final readings were between 0-1ppm which were indicative of a non-smoker.

The fact that Bob completed the programme through to the end and was not 'lost to follow up' also helps in evaluating the success of the intervention.

The intervention was also evaluated by a client feedback form that all clients are invited to complete at the end of the programme (appendix 14). It comprises partly of a Likert scale where clients are asked to rate different aspects of the intervention. There are also two open-ended questions where clients are invited to provide overall comments on their experience of the intervention. Bob responded 'about right' to the majority of Likert scale questions apart from the length of the program, to which he responded 'too short.' He mentioned how a couple of extra weeks to the seven week program would be beneficial particularly for those individuals who struggle in the first couple of weeks, as he did. Fortunately the fact that the group I run is a relapse prevention group in addition to it being a rolling group gives clients like Bob the flexibility to attend extra sessions if they feel they need them. In the comments section Bob provided only positive comments, giving particular praise to the support he received from the

other group members and myself. He also provided suggestions for others trying to quit by advocating the use of Nicotine Replacement Therapy at the recommended dosage and exercising willpower.

Other methods of evaluation included verbal feedback from the clients and the other group members. When Bob received his certificate he told me he was appreciative of the fact that I had addressed his commitment to the programme because it helped shake him out of his comfort zone. He also relayed this information to another group member who fed this back to me. This all provides helpful feedback for the advisor when reflecting on their conduct in implementing the intervention.

Finally, although the programme lasts for seven weeks I am still in regular contact (mainly through phone calls) for up to 12 weeks with clients using NRT because I provide them with their prescriptions. Therefore although quit rates beyond 2-4 weeks are not recorded officially, I still get an insight into a slightly longer term quit rate with these clients, which also helps me evaluate the success of the intervention. After I had provided Bob with his final prescription at 8 weeks post quit date, he was still abstinent.

3.1.Reflection

I feel that the 4 week period after quit date is not a sufficient length of time to deem an individual a ‘successful quitter’. When I explained this four week quit status to the group members they would all disagree with its basis, many drawing attention to the fact that they could quite easily stop for a month but would struggle longer-term. Hence I feel more long-term

follow up checks are needed to sufficiently evaluate the intervention. This is why I enjoy being able to stay in contact with my clients (who are using NRT) for up to at 12 weeks because I get an insight into their longer-term quit status.

Also I do not personally evaluate the success of the intervention based on 4 week quit status alone. Some clients may only manage to remain abstinent in the last week of the programme and continue to be abstinent after the programme finishes. Although they would not have been recorded as a successful quitter according to the national guidelines, I would still personally perceive them as a success. Also if clients do relapse and do not manage to stop smoking at the end of the programme I feel they learn so much from each quit attempt (which I often hear from clients in their first session) that I do not regard the whole process as a failure for them. Also, as research indicates, smokers often need to make repeated quit attempts before abstinence is achieved (Cohen et al., 1989).

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Appendices

Appendix 1

[redacted]

__ /__ / 200_

Dear Dr _____

Re: Request for Zyban prescription for a client registered with your practice

Client Name:_____
Date Birth:_____
Address:_____

The above patient, who is registered with your practice, is currently attending stop smoking support sessions with me. I have fully discussed treatment options and assessed the patients suitability for treatment. The patient appears highly motivated and has set a quit date of - _____. I would appreciate it if you could consider prescribing a course of Zyban to support your patient in their quit attempt. I have indicated in the table overleaf if the patient has any of the cautions or contraindications for Zyban.

Initially a 4-week prescription would be recommended, starting at 1 tablet of 150mg for the first 7 days then increasing to 2 tablets of 150mg for the remainder of the course. S/he will need to start this a minimum of 8 days before his/her quit date. Therefore they will need to have the Zyban by _____. I will be seeing your patient and monitoring the Zyban use weekly. I will send you another letter 2 weeks following commencement to request a further 4-week prescription. This will complete the 8-week course of treatment.

If you have any questions or concerns, feel free to contact myself or the specialist stop smoking service on the number above.

Yours sincerely
Level 2 Advisor

Level 2 Advisors Contact Details:

Zyban- Cautions and Contraindications:

In discussion with your patient (named overleaf) I have gone through the following cautions and contraindications for Zyban. I have ticked any relevant boxes.

Contraindications:

1. Anyone under 18 years of age	
2. Pregnant, breastfeeding or actively trying to get pregnant	
3. History of epilepsy or any seizure disorder	
4. History of eating disorder (e.g. anorexia)	
5. Severe liver disorder	
6. History of bipolar affective disorder (manic depression)	
7. Use of monoamine oxidase inhibitors (MAOIs)	
8. Previous adverse reaction to Zyban	

Extreme caution:

9. History of head trauma	
10. Brain tumour	
11. Use of drugs that lower the seizure threshold (e.g. antipsychotics, antidepressants, theophylline, systemic steroids, antimalarials)	

Caution:

12. Alcohol abuse	
13. Withdrawal from tranquilizer use	
14. Diabetes	
15. Use of stimulants or anorectic products	
16. Use of levodopa	
17. Elderly patients (the dose should generally be 150mg per day)	
18. Patients with liver or kidney dysfunction (the dose should generally be 150mg per day)	
19. Use of any medication which may interact with Zyban	

Appendix 2

Group Progress at time of Bob's arrival

	Age	Original daily cigarette consumption	Duration of group attendance	Preparation Time	Progress to date
Janita	56 years	40	6 weeks	2 weeks	Currently quit for 3 weeks
Steve	62 years	30	1 week (did not attend last 2 weeks as sick with flu)	2 weeks	Quit date set for following week
Louise	34 years	20	4 weeks	2 weeks	Currently quit for 1 week
Terry	37 years	20	4 weeks	2 weeks	Currently quit for 1 week
Max	42 years	20	5 weeks	2 weeks	Had relapsed first week and currently quit for 1 week.

Appendix 3

Bob's profile

Age	65 years
Daily Cigarette Consumption	40 cigarettes
Dependency	Smoking within 5 minutes of waking up
Health Conditions	Asthma, Arthritis
No. of Previous quit attempts	1
Longest period quit	1 day
Previous support to quit	No

Appendix 4

SMOKEFREE

[redacted] PCT

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
☐ Sure Start (member no)…….
☐ Family/Friends
☐ From a previous user of the service
☐ Newspaper/Magazine_____
☐ Tube/Bus shelter
☐ Other (please specify)_____

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 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) 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

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						

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

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

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

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

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) Please circle a number to show how confident you are that you will manage not to smoke for the next <u>week</u>:

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

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

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

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

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

OFFICIAL USE ONLY: Four Week Follow Up

Has individual smoked in the last 2 weeks? Yes ☐ No ☐ Lost to follow up ☐

Advisor: _____ Registration Number:_____

Appendix 5

SMOKING DIARY

Filling in this diary sheet will help you think about your smoking patterns. Try to do it over the course of a few days before your quit date. Understanding when and why you smoke is important to help you plan what you can do at these times instead of smoking. This may help you get through the first few weeks without cigarettes.

Day	Time	In what situation did I smoke (e.g. with others, alone, location)	How I felt before (e.g. bored, happy)	How I felt after (e.g. stressed, relaxed)	When I quit, I plan to deal with the situation by…

Appendix 6

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.

Phone Numbers and Websites

Smokefree [redacted] Team

To speak to one of our advisors, phone:

Freephone: [redacted]

Or e-mail: stopsmoking@[redacted]

Both these numbers also employ counsellors who are trained to work with smokers

Quitline: 0800 00 22 00
(9am - 9pm, 7 days a week)

The NHS Smoking Helpline: 0800 022 4 332
(7am – 11pm, 7 days a week)

Excellent websites for Health professionals, smokers and ex-smokers

http://smokefree.nhs.uk/
http://www.ash.org.uk/
http://www.treatobacco.net/en/index.html

Appendix 7

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 8

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 9

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 10

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

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 11

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 and to attend our relapse prevention group. 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 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 12

[redacted] [redacted]

THIS IS TO CERTIFY THAT

HAS SUCCESSFULLY GIVEN UP SMOKING

Authorised By: _____

Stop Smoking Advisor

Appendix 13

Weekly log of Bob's sessions

	Confidence Score	Carbon monoxide reading (ppm)	Number of cigarettes smoked	Quit status	Medication used
Week1: Preparation Session	5	24	40 a day	Not Quit	N/A
Week 2: Quit Week	7	18	20 a day	Not Quit	24 hr/21mg Patch and Inhalator
Week 3: 1 week post quit date	5	14	6 a day	Not Quit	24 hr/21mg Patch and Inhalator
Week 4: 2 weeks post quit date	6	15	6 a day	Not Quit	24 hr/21mg Patch and Inhalator
Week 5: 3 weeks post quit date	8	1	0	Quit	24 hr/21mg Patch and Inhalator
Week 6: 4 weeks post quit date	8	1	0	Quit	24 hr/21mg Patch and Inhalator
Week 7: 5 weeks post quit date	9	0	0	Quit	24 hr/21mg Patch and Inhalator
Week 8: 6 weeks post quit date	9	1	0	Quit	24 hr/21mg Patch and Inhalator
Week 9: 7 weeks post quit date	9	0	0	Quit	24 hr/21mg Patch and Inhalator
Week 10: 8 weeks post quit date	9	0	0	Quit	24hr/14mg Patch and Inhalator

Appendix 14

FEEDBACK: PLEASE TELL US WHAT YOU THINK

We would 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 did not, on the form below.

1. The group started approximately 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.

SECTION C

PROFESSIONAL PRACTICE

DIRECT THE IMPLEMENTATION OF INTERVENTION COMPETENCE

Providing Clinical Supervision to Health Trainers

DIRECT THE IMPLEMENTATION OF INTERVENTION COMPETENCE: PROVIDING CLINICAL SUPERVISION TO HEALTH TRAINERS

1. Needs Assessment Report Explaining why a Particular Intervention is/was Necessary

The intervention implemented was the use of five Health Trainers (HTs) within my Primary Care Trust (PCT). HTs are recruited from the local community and their role is to i) raise people's awareness of key health messages ii) signpost to relevant services and iii) advise, motivate and support people from 'hard to reach' groups to stop smoking, increase physical activity and improve their diet (Department of Health, 2008). With regards to definition of 'hard-to-reach', the Department of Health document, 'Addressing Inequalities: Reaching the Hard-to-Reach Groups – National Service Frameworks' (2002), state that certain groups are marginalized from healthcare services and therefore 'harder-to-reach' for healthcare services, whose goal is to provide equitable healthcare for all populations. Examples of groups who tend to suffer from social exclusion include, individuals living in deprived areas, homeless people and refugees (Department of Heath, 2002). The support HTs provide is based on behaviour change techniques grounded in psychological science (Department of Health, 2008). For example, helping clients set goals and plan on how to achieve them is based on Control Theory (Carver & Scheier, 1998), which purports a goal hierarchy consisting of systems concepts (abstract goal), principles (action goal) and programmes (courses of action). The rationale behind the Health Trainer scheme, as outlined by the government White Paper, 'Choosing Health' (Department of Health, 2004),

is that recruiting individuals from within the local community will aid in accessing hard-to-reach groups from these communities and they will also have a greater understanding of the day-to-day concerns and experiences of the people they are supporting.

The introduction of HTs into the National Health Service (NHS) was deemed a priority initiative in the 'Choosing Health' government White Paper (Department of Health, 2004), in an attempt to address the rising problem of health inequalities. My PCT was one of the spearheads in the field introducing the initiative in 2003. There was a need for HTs in my PCT, from the local community's, PCT's and stakeholders' point of view. With regards to the local community's point of view this was primarily a health need. The 2005/06 PCT Annual Public Health Report conveyed health inequalities in the borough. It stated that the borough is the 19th most deprived in the country with a lower life expectancy than the national average. There are extremes of wealth and poverty with some very affluent areas but in the most deprived areas there are i) lower life expectancies ii) higher standardised mortality ratios (SMRs) for premature death from all causes and iii) lower levels of perceived good health. Therefore the Heath Trainers were to be situated in the most deprived wards of the borough.

From the PCT's perspective, having HTs accessing hard-to-reach groups would assist in meeting its commitment to reduce health inequalities in the borough, which was outlined in its Annual Public Health Report ([redacted] PCT, 2006). HTs would also provide additional support to services within the Public Health department, including the Stop Smoking Service and Healthy Eating Team, to help them meet their targets, for example with referrals to the service. In addition they would help streamline healthcare by providing

basic care which would help to ease workload for General Practices (GPs), in which they were to be primarily based.

With regards to the stakeholders' perspective, the emphasis on prevention rather than cure in the NHS, through the targeting of lifestyle factors, is now increasingly viewed as the economically sound option (NHS Institute for Innovation and Improvement, 2007).

1.1.Reflection

I was enthusiastic about the concept of HTs, mainly because it was such a high profile scheme encompassing health psychological theory and because it was addressing the issue of health inequalities within the borough. However, my one major concern was that the rationale for HTs was targeting hard-to-reach groups yet they were to be predominantly based in GP practices. Therefore they were to be working with individuals who had already accessed healthcare services. However, I felt that at least this was a step in the right direction and hopefully if the programme was effective in the GP practices further opportunities to broaden the programme could be explored.

2. Plan of Supervision for Specified Intervention

To ensure effective implementation of the HT scheme into the PCT, different bodies in the PCT were assigned various responsibilities relating to the role. One important role to be

conducted was the clinical supervision of the HTs. The NHS Executive (NHSE) defines clinical supervision as a:

> "….a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills."
>
> NHSE (1993, p.3)

Clinical supervision is considered to sit within the clinical governance framework in the NHS, not as a management tool but rather a support for the development and improvement or maintenance of high quality clinical and professional practice in the delivery of patient care. As Butterworth and Woods (1998) suggest:

> "participating in clinical supervision in an active way is a clear demonstration of an individual exercising their responsibility under clinical governance. Organisations have a responsibility to ensure that individual clinicians have access to appropriate supervision and support in the exercise of their joint and individual responsibilities."
>
> Butterworth and Woods (1998, p.1)

As discussed earlier, part of the premise of the HT programme was to recruit individuals who the local community would identify with. As a result this meant that formal health qualifications were not required for the HT role. Therefore the role of clinical supervision in the implementation of the HT scheme was particularly important.

This clinical supervision of HTs was originally provided by my Manager who was Head of the Stop Smoking Service and a Health Psychologist. The main premise for a Health Psychologist providing the supervision was because the HTs would be engaging in a range of health behaviour change techniques based on health psychological principles, such as exploring self-efficacy (Bandura, 1997), action planning (Sniehotta, Scholtz & Schwarzer, 2005), self-monitoring (Bandura, 1998) implementation intentions (Gollwitzer,1999) and motivational interviewing (Rollnick & Miller, 1995). When I joined the service I was to take over this clinical supervision from my Manager for two of the HTs. As my role at the service was a Health Psychologist in Training and I was working within the smoking field, which was one of the health areas addressed by the HTs, I was deemed suitable for the role. I was also to have regular monthly contact with my Manager to reflect on issues brought up with the HTs' supervision.

White et al. (1998) report that the most common arrangement of supervision is one-to-one supervision. However, other arrangements including group supervision, peer group supervision and network supervision are also used (Houston, 1990). My role was to provide one-to-one supervision for two of the HTs, for a period of one hour, on a monthly basis, which is in line with recommendations from research into effective supervision (Winstanley, 2001; Edwards, 2005) and all the sessions were to be logged (see appendix 1 for examples). All the HTs were also to receive group supervision from a colleague of mine who was also a Health Psychologist in Training. This was to allow for sharing of collective advice and support and for group learning activities focused on the HTs' continual professional development (CPD).

My approach in the one-to-one supervision sessions was based on Proctor's (1986) three-function interactive model of supervision. This states that supervision can be summarised into normative (managerial), formative (educative) and restorative (pastoral support) components. This was used to inform a supervision plan, which was developed for the one-to-one supervision sessions through discussions with my Manager, the group supervisor and my initial supervision meeting with the HTs (appendix 2). So for example, managerial aspects of my role included ensuring adequate record-keeping and time-management, educative aspects involved encouraging reflection and identifying and addressing training needs, and restorative aspects involved assisting with the management of emotional stress that could occur in the role.

The supervision plan provided structure to the sessions and it was also important in outlining boundaries for the sessions. Although I was providing clinical supervision the HTs were also receiving general supervision from their Line Managers and I felt it was important that distinctions between the two should be drawn. Research recommends that having a supervision contract, where there is agreement between supervisee and supervisee on the aims of the supervision, along with practical arrangements such as the frequency, duration and confidential arrangements of the supervision, is important (British Psychological Society, 2002; Ritter et al., 1996). Although a formal written contract was not developed a verbal contract was agreed in the first session, which addressed the fore-mentioned issues.

The methods employed to achieve the objectives of the supervision were based on guidance from my Manager, recommendations from a literature review and my own personal experience of supervision. The methods employed were directive, problem-

focused and skills based, which research has shown is preferred by more inexperienced practitioners (Tracey et al., 1989). These methods firstly included discussion (Kavanagh et al., 2002). For example, the HTs would be invited to bring specific client case studies to the supervision to discuss key learning points from clients they had seen in the past or challenges they were facing with current clients. The aim was to guide the HTs in their clinical practice and also to encourage them to reflect on the theoretical basis of their practice (Hirons et al., 1993). Another method employed was regular observation of the HT's clinical practice (Kavanagh et al., 2002). This would take place quarterly over the year and involved me observing their clinics for a full morning or afternoon session. I would then give verbal feedback on their practice in our supervision sessions (Kavanagh et al., 2002), for example, by discussing their use of motivational interviewing techniques, non-verbal cues and completion of paperwork. Any areas for development were addressed through goal-setting and progress would be assessed in future sessions. If areas for development were identified that could potentially be applied to all the HTs, then these were fedback to the HT's group supervisor as a potential learning topic for a future session. This would also work vice-versa whereby if the group supervisor noted areas for individual development this was relayed back to me and discussed in the individual supervision sessions.

Another issue which I considered was my supervision style and developing a good supervisory relationship with the HTs. Kilminster and Jolly (2000), state that the quality of the relationship between supervisor and supervisee is probably the single most important factor for effective supervision. Important aspects of developing a good working relationship include, for example, the supervisor demonstrating empathy and respect

towards their supervisees and that they are supportive of them (Kennard, Stewart, & Gluck, 1987; Watkins, 1995). I found that techniques I had developed in my clinical work with clients (e.g. empathy and active listening) were all skills which I could transfer across to my supervision sessions with the HTs to help build a good working relationship with them.

2.1.Reflection

As this was to be my first experience of providing supervision I was nervous about carrying it out. My concerns were primarily about getting the balance between the managerial, educative and pastoral support roles of the supervision correct. However, I did recognise that this would come from experience. Also knowing I had regular supervision with my own Manager and monthly health psychology meetings with my Manager and other Health Psychologists in Training, to discuss any issues I had, was reassuring. As I was taking over these supervision sessions from my Manager I was debriefed on some of the challenges to face, for example, I was informed that one of the HTs had problems with organisation and time-keeping, which was helpful to know in advance.

The fact that the HTs were not from a professional health background was another challenge I discovered, especially as I had to be responsible for encouraging reflection and updating them on the health psychology techniques underlying their clinical practice. I found reflecting on my teaching and training competence in regards to tailoring teaching methods to the audience, being aware of different levels of knowledge and individual

learning styles (Honey and Mumford, 2001) particularly useful and helped build my confidence for dealing with this.

3. Reflective Analysis of the Problems Encountered in Implementing the Intervention and Supervising its Implementation

There were a number of challenges which were encountered when provided clinical supervision to the HTs (who will be referred to as HT1 and HT2).

The first major challenge revolved around boundaries in clinical practice and working within ones' own limits of competence. This relates to the principle of competence within the British Psychological Society's Code of Ethics and Conduct (2006), and the standards of i) recognising the limits of own competence and ii) ethical decision-making. The HTs in their initial training were informed of the importance of working within their designated job role and not taking on responsibilities which fell out of this remit, due to ethical reasons. During discussions about clients it transpired that HT1 was trying to assist some of her clients with a lot of emotional stressors that were taking place in their lives and that a significant proportion of her sessions were being taken up by this. As a result she was left struggling trying to deliver the intervention effectively in the session. I discussed with HT1 what she felt her duties were to the client and she said although she knew it was to assist with healthy eating, stopping smoking and/or increasing physical activity, she felt 'bad' for interrupting clients and steering the conversation back to the intervention. I empathised with her situation because I knew this could occur with clients, particularly

when discussing coping strategies and support networks, which were part of the intervention. However, I encouraged her to reflect on what the possible repercussions of this could be. She acknowledged the potential of being held accountable for ill-advising clients due to not being professionally qualified and accepted how this could prove a disservice in the end, especially given the fact that the service she should have been providing was not being delivered efficiently. We then discussed a number of strategies to help her with this. For example, she mentioned how at the start of the programme she did not really outline the boundaries of the session to clients, for example, specifying the time slot she had available and outlining what the objectives for each session were. She agreed that specifying this at the start would help define both her and the client's role in the session. The HTs were also encouraged to refer to other services and provided with materials to help them do this, such as referral forms and leaflets. This was particularly important in addressing the 'feeling bad' aspect HT1 described because support was still ultimately being provided to the client. Speakers from other services were also invited to the HT's group supervision sessions to help them build links with other agencies and actively refer into them.

At other times the issue of working within clinical boundaries was compounded by external agencies. For example, referrals for HT services were made by a number of agencies but predominantly staff within GP practices, such as Doctors and Practice Nurses. The HTs were provided with screening guidance on the types of clients they could see (appendix 3). It was fed back to me by a Dietician, that HT1 had been seeing clients with a Body Mass Index (BMI) of 40 or above, which was not permitted in the screening guidance because such clients were considered to require more specialist assistance and needed to be

referred straight to a Dietician. When I discussed this with HT1, she said she was aware of this but because GPs had been referring such clients to her, she felt she was able to see them. It was reiterated to all the HTs in their group supervision that it was important they adhered to the screening guidance but it was also recognised that an awareness drive amongst other health professionals of the HT role needed to be conducted. Both HT1 and HT2 discussed how they felt other health professionals were not sufficiently aware of their role and unclear over referral guidance. As a result all the HTs were encouraged to attend meetings in their allocated general practices and give presentations on the service they offered and the clients they could see. The group supervision meetings were used to help develop these presentations. Also promotional literature of the HT service was developed and distributed in all the practices. These measures assisted to a large degree and although the HTs still occasionally received inappropriate referrals they forwarded them on to the relevant health professional instead of seeing the clients themselves (along with contacting the initial referrer about the inappropriate referral).

Another challenge I faced was in regards to providing feedback to HT2. As McKimm (2009), states, feedback in supervision is a vital part of education and training, which if successfully conducted assists in motivating and developing learners' knowledge, skills and behaviours. Also they mention how it helps learners to maximise their potential and professional development, raising their awareness of strengths and areas for improvement along with identifying actions to be taken to improve performance. As mentioned earlier one of the methods employed in the supervision sessions involved HTs presenting client case studies to help reflect on their practice. This was also used as an opportunity for me to feedback on their practice. HT2 tended to present clients where the

process had been smooth running and the outcome with the client had been successful. I felt it was also important to discuss challenging clients to assist with the HT's learning and development and so proposed this to HT2, to which she agreed. When HT2 presented a challenging client case study, I firstly praised her for the positive actions she had taken with the client, as recommended by Hesketh and Laidlaw (2003) before suggesting any recommendations to assist with her practice, for example, carrying out follow-up calls to help reduce lost to follow up rates. However, I noticed H2 would become very defensive and would be quick to point out that she had already implemented my recommendations to no avail. I was mindful of our relationship and I was conscious that I did not want to upset or offend her, which as Hesketh and Laidlaw (2002) state can be a barrier for supervisors when providing feedback. However, I also considered whether there was more I could be doing to help create a supportive environment in our relationship, which did not incite defensiveness from HT2. Barnet et al. (2007) state that it is important for supervisors to create a safe environment in which supervisees can openly discuss their work, address insecurities and concerns they experience. This is because if supervisees are constantly worried about being evaluated, pleasing the supervisor, or just 'not messing up' they will be more likely not to share negative client experiences with supervisors and will tend to share their perceived 'successes' rather than their 'failures'. This is a pattern that will tend to limit potential for growth and learning. Hence I reflected on whether this could be occurring with HT2 and discussed the issue with my Manager. It was acknowledged how given the lack of formal professional training amongst the HTS I may have taken a more prescriptive approach with them and tried to direct them instead of making the process collaborative. Hence it was recommended when providing feedback, for example, before making recommendations to the HTs, to allow them greater opportunity to self reflect first,

through for example, the use of open questioning such as, 'If you were doing the session again what would you do the same next time and what would you do differently? or 'did the session go as planned – if not why not?' as recommended by McKimm, (2009). I found this approach to be very effective and felt I was able to build a better supervisory relationship as a result, which was more conducive for effective provision of feedback.

Another challenge was maintaining the boundaries between the clinical supervision I provided and the supervision provided by the HTs' Line Managers. Although boundaries had been outlined at the outset, they were difficult to adhere to in practice. This was because changes in the HT's Line Managers, who were from the District Nursing (DN)/Health Visiting (HV) Teams, were a destabilising force for the HTs. Often the HTs would go for a substantial amount of time without a Line Manager and as I was a source of continuity for the HTs they felt I was the only person they could discuss line managerial issues with. The fact that the Line Managers were from the DN/HV teams also compounded matters because the HTs did not feel that they knew enough about their roles and duties to be able to provide effective supervision. The Line Managers from the DN/HV teams also agreed that they found it difficult to provide appropriate supervision. This issue was mentioned by all the HTs in the service and all the Clinical Supervisors, including myself raised the issue with our Manager. My Manager discussed it with the Senior Management Team who were coordinating the programme and eventually new systems were put in place where line management was provided by the Manager of the Health Promotion Team who was actively involved in the delivery of the HT programme.

Other challenges experienced involved adapting my supervision style when dealing with HT1 and HT2. They were very different in personality and also in their working style.

For example, HT2 was extremely organised in her working and more conscientious whereas HT1 was more disorganised and haphazard in her approach, which was reflected in her paperwork and time-keeping. As a result I had to implement more goal-setting strategies with HT1, for example, by setting mutually negotiated deadlines to implement a new filing system and making greater use of alarm and calendar functions on work mobiles and email.

Finally, there were also challenges in encouraging the HTs to reflect on the health psychological theory behind their practice. I was mindful of their lack of academic background and so felt using too much psychological jargon may be quite intimidating and could potentially alienate the HTs. Therefore I tried to keep that this to a minimum. Instead when the HTs discussed their clients in the sessions or when I provided feedback on my observations of their clinical practice, I drew their attention to the ways in which they had incorporated health psychological theory into their practice to show them how they were already making use of it. For example, HT2 spoke about how a client wanted to give up smoking because he thought he was at high risk of getting lung cancer because his doctors had warned him and his father had died of the disease, so I commented on how this related with the perceived susceptibility component of the Health Belief Model (Rosenstock, 1966). When alternative and additional ways of working were explored to deal with a particular client scenario, I used this as a way to introduce new concepts to them. My intention was to reduce the fear factor around making use of theory, which over time the HTs agreed had been the case.

3.1.Reflection

Overall there were a combination of organisational and personal forces which impacted on the provision of clinical supervision for the HTs. When dealing with the organisational aspects, such as the line managerial issues, I found this a very frustrating process at times. This was because there were so many bodies involved in the HT initiative in the department that needed to be consulted before changes could be implemented. This ended up slowing the whole process of change. Fortunately over a period of time the organisational structure became more streamlined (by having the Manager of the Health Promotion Department coordinating the initiative) which improved communication. I appreciated that any new initiatives that are implemented, such as the HT initiative, are going to be subject to change and revision. However, I felt that a greater understanding of the unsettling effects this had on the HTs also needed to be recognised by the Senior Management Team. This related to the restorative (pastoral support) aspect of my role, discussed earlier. As a result a lot of my role as a supervisor to the HTs within the organisation, was about giving voice to their concerns, through for example, raising these concerns with my Manager. I also found that my role as a HT supervisor within the organisation was about being an advocate for the initiative, through for example, raising awareness of their role to other staff members in the organisation.

There were also personal forces impacting on the supervision process. Establishing rapport with the HTs in the supervision sessions and building trust within the relationship occurred over a period of time. This was achieved by making the supervision process a collaborative one and by listening to and addressing concerns the HTs had. I enjoyed the joint problem-solving aspect of the supervisory relationship and found it to be a highly

rewarding when solutions were identified and implemented successfully. This at first was a challenge for me, particularly with the formative (educative) aspects of the supervision discussed earlier, because I had taken a more directive approach. However, once I started to change this approach through allowing greater opportunity for self-reflection by the HTs, I was able to adapt.

Supervising two very contrasting personalities was also good experience for me. I had to come out of my comfort zone with both of them at different times, especially with the normative (management) aspect of the process and also particularly when dealing with HT1 with regards to seeing inappropriate referrals and addressing organisational and time keeping issues. This has helped to build my confidence for dealing with similar situations in the future. With regards to the formative (educative) aspect of the supervision session, supervising individuals who did not have an academic background was good for developing my teaching and training skills because I had to adapt my approach accordingly. This was particularly pertinent when encouraging the HT's reflection on health psychological theory in their practice. Again I found this development to be a process because I had to initially scope out the HT's knowledge base and learning styles and then tailor my approach accordingly.

Overall the process of supervising the HTs was challenging, particularly in the initial stages and I found it to be a progressive learning curve. Receiving positive feedback from the HTs as a result of the sessions made the process highly rewarding.

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Appendices

Appendix 1

NB: PHA refers to Public Health Assistant which was the original name for Health Trainer

HT1 supervision session log

Date	Area discussed	Issues discussed	Action points
21.08.06	Supervision with previous Line Manager	Had more supervision with previous line manager than current one. Feels current line manager not meeting frequently enough. Discussed organising a meeting to discuss these issues with line manager.	[redacted] to book supervision meeting with line manager
	[redacted] expectations regarding clinical supervision	[redacted] would like the opportunity to discuss clients, opportunities for training, CPD.	
	RK's role in supervision session	Provide guidance, advice, education and support with clinical work – through 1:1, observations. [redacted] happy with this arrangement.	
	Clinic update	[redacted] feels more confident in her ability now. Community work in September – [redacted] on Thursdays at [redacted] Health Centre 3 mornings a week – Mon, Wed, Fri. In [redacted] lack of space to work as sharing with District Nurses. But refurbishment currently being undertaken	

	Other duties	[redacted] Centre Low numbers – this month is dragging. Not many new referrals but [redacted] does not feel this is due to unawareness of the service. Currently working on mens fitness- exercising in small groups. Promoting service. Both morning and afternoon sessions. On Thurs session with [redacted] Will give them 3 more months, if won't pick up will move on. Is a steady drip, but is getting better at referring. [redacted] did attempt approaching others. [redacted] sent 3 referrals, the other 2 were not successful. [redacted] GP- from [redacted] – No room currently available.	
	Client discussion	Complex patients – Mental Health client – Had 1 quit attempt but failed. Will see how it goes, if problems then will refer her on to the specialist service. Will develop a plan of how to approach client – to discuss in next meeting September – first 2 weeks Hypertension week – Will write down EMIS instructions on how to enter data	[redacted] to develop plan for next meeting [redacted] to write down EMIS instructions and place them in convenient location.
	Next Meeting Observation of Session	20.09.06 Arrange time for observation of session	[redacted] to propose dates

20.09.06	Client discussion	Contact to be made with care coordinator of MH client. Appears client motivated – need to develop further coping strategies	[redacted] to explore further coping strategies with client
		Observation date	Date set for 28.09.06. [redacted] to inform client's of RK's attendance in clinic to get consent.
	Diary Auditing	Will set day aside to do diary and weekly self-report.	[redacted] to set day aside
	Weighing Scales	Problems in practice regarding access to weighing scales. Approached GP about getting another set of scales. Questions over funding.	[redacted] to speak to [redacted] and Line Manager.
	Arrival of Healthy Eating Advisor	Discussed concern over role overlap. However now feels there is boundary between the jobs. Will still meet with [redacted] as part of role is to carry out community work and Cook and Eat sessions.	[redacted] to speak to [redacted]
13/02/07	Line Manager changes	[redacted] discussed feeling lost about changes regarding her line manager. Is confused over whether her line manager has left and if so who will be replacing her. [redacted] spoke to [redacted] about it – she will be emailing [redacted] to find out what's going on.	[redacted] to email [redacted] about who will be carrying out her appraisal and who can sign her annual leave card.
		Is also unsure about who will be carrying out her appraisal.	[redacted] to email [redacted] to get a copy of her job description for the meeting.
	Lack of referrals in clinic	As result of low referrals in [redacted] has	[redacted] to arrange meeting in [redacted]

		arranged a meeting with the GPs on Monday where she will discuss her role and the service she provides. [redacted] to organise something similar with [redacted]	[redacted] to talk about her service.
	Complex clients	[redacted] discussed client with mental health needs who is relapsing frequently and setting multiple quit dates. Discussion on referring client to specialist service. Client interested in attending group.	[redacted] to discuss specialist stop smoking service with complex client, possibly refer to group.
	Obese clients	Discussed [redacted] views on dealing with obese clients exceeding BMI limit. Said there are no problems now. For such clients she states she provides one information giving session and then refers them on. Discussed how language barriers with clients have an effect sometimes – result being they don't complete a [redacted] form. Is aware of interpreting service or will ask client to belong along friend/family member.	
	Training	Would like training in alcoholism.	RK to discuss with [redacted]
	Observation of session	RK to observe [redacted] clinic	[redacted] to provide RK with suitable date for observation session.
	Date of next meeting	13th March 2007 2.00pm	

HT2 supervision session log

Date	Area discussed	Issues discussed	Action points
09/08/06	Clinics	Was doing sessions at [redacted] Surgery but pulled out in July 06 because of low turnout. Was also confusion amongst the practice staff over the role of a PHA - [redacted] was asked to conduct health checks. Was discussion to run clinic at [redacted] but practice didn't actively pursue this so no action took place. Now at [redacted] where she has extended her sessions to 1 and a half days a week. Currently has 4 new clients and 5 follow-ups. All her bookings are full until November 06.	
	Other Duties	Also conducts a weekly health walk from [redacted] pharmacy and group session health talks for Bangladeshi women. Wednesday mornings and Thursday afternoons	
	[redacted] expectations regarding clinical supervision	Would like identification of training needs, discussion of clients, is stressful job and needs support. Would like to know about health psychology theory behind interventions carry out. Is happy with sessions every month and being observed.	RK to develop timetable for future supervision sessions to address these needs.
	RK's role in supervision session	Provide advice, met training needs, support, feedback on clinical practice.	

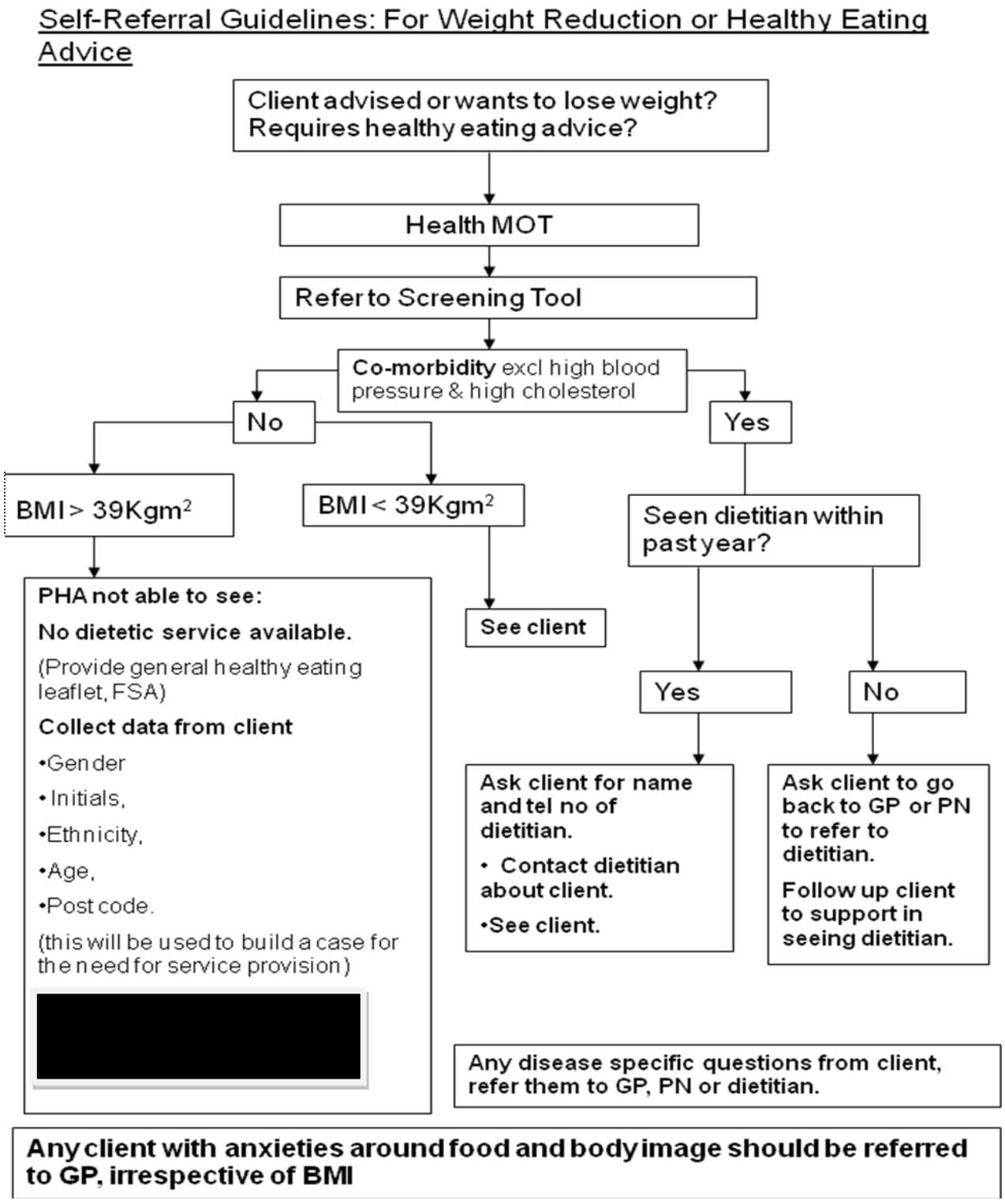
	Observe Session Line Manager Next Meeting	Agreement to observe a session. [redacted] to email RK dates and get client permission for observation of session. Line manager [redacted] 09/10/06	[redacted] to email date for observation session and get consent from clients.
09/10/06	Dealing with changes in working Clinics Other Duties Inappropriate referrals Client case study Line Manager Next meeting	Increased paperwork and weekly work diary. Discussed importance of setting aside a regular time every week to complete the diary, i.e. Monday morning. [redacted] found paperwork confusing at the start but is gradually getting used to it. Pleased with new posters. Is having it individually tailored for own clinic. [redacted] Centre has recently joined with [redacted] Centre. [redacted] referrals are a bit slow. Now 2 ½ sessions a week at [redacted] Centre. Is happy with own work in the clinics, no problems. Attended quite a few health promotion events over the last few weeks, doing breast screening, over 50s and royal mail event this week. Feels comfortable dealing with inappropriate referrals. Discusses any problems with fellow health trainers and now feels able to approach line manager. Client case study presented – will update on client progress next session. Needs to book another supervision meeting with line manager. TBC	[redacted] to complete work diary every Monday [redacted] will update next session [redacted] to book supervision with line manager Date of next supervision to be arranged. RK to email.

28.02.07	Clinics	[redacted] Centre a bit slow [redacted] Centre – Has more clients Tackling obesity with [redacted]	
	Reflection on how Bangladeshi clients differ from white clients	Believes that Bangladeshi clients do not like to attend stop smoking program through because they like success and fear failure. They feel embarrassed if they start smoking again and so don't like seeing the GP or pharmacist or other health professional.	
	Complex client	Client who is not relinquishing his last cigarette. [redacted] has talked through a variety of strategies with him, he is using the inhalator, she has stressed the importance of stopping altogether as risk of relapse, negative health impact of smoking any cigarettes etc. Will see how he goes this week.	
	Client case study Observation of clinic	Client who lost his recommended weight. [redacted] to email suitable dates to [redacted] and [redacted] to arrange with client.	RK to email suitable dates to [redacted] for observation of clinic.
	Next meeting	TBC	Date of next supervision to be arranged. RK to email
	Training	Booking slot on equality and diversity training	[redacted] to arrange

Appendix 2
Supervision Plan

Educative	
Reflection on health psychological basis of practice	To ensure HTs are aware of the health psychological basis of the interventions they are providing
Audit and update use of general health psychology techniques	To make sure the techniques being used by the HTs are reflective of the latest evidence base
Training needs	To ensure HTs receive the correct training to conduct their role effectively and for continual professional development
Observation of practice	To review HTs clinical practice, identify positive aspects of working and identify any areas for improvement
Use of reflection logs	Encourage the HTs to reflect on their practice and provide opportunity for discussion in sessions
General client discussion	To support and guide with client issues to ensure to enhance clinical practice and for continual professional development.
Client case studies	To assist with client formulation, application of health psychological theory to enhance clinical practice and for continual professional development
Provision of feedback	To provide constructive feedback to enhance clinical practice
Ethical considerations	Implement and reflect on ethical responsibility in practice
Managerial	
Record-keeping	Ensure paperwork is used appropriately and kept up-to-date in an organised manner
Time-keeping	Ensure adequate time-keeping for client appointments, meetings and general day to day working
General time-management	Make effective use of time to ensure duties completed appropriately
Pastoral support	
Provision of support and advice	To ensure necessary support provided to conduct role effectively

Appendix 3

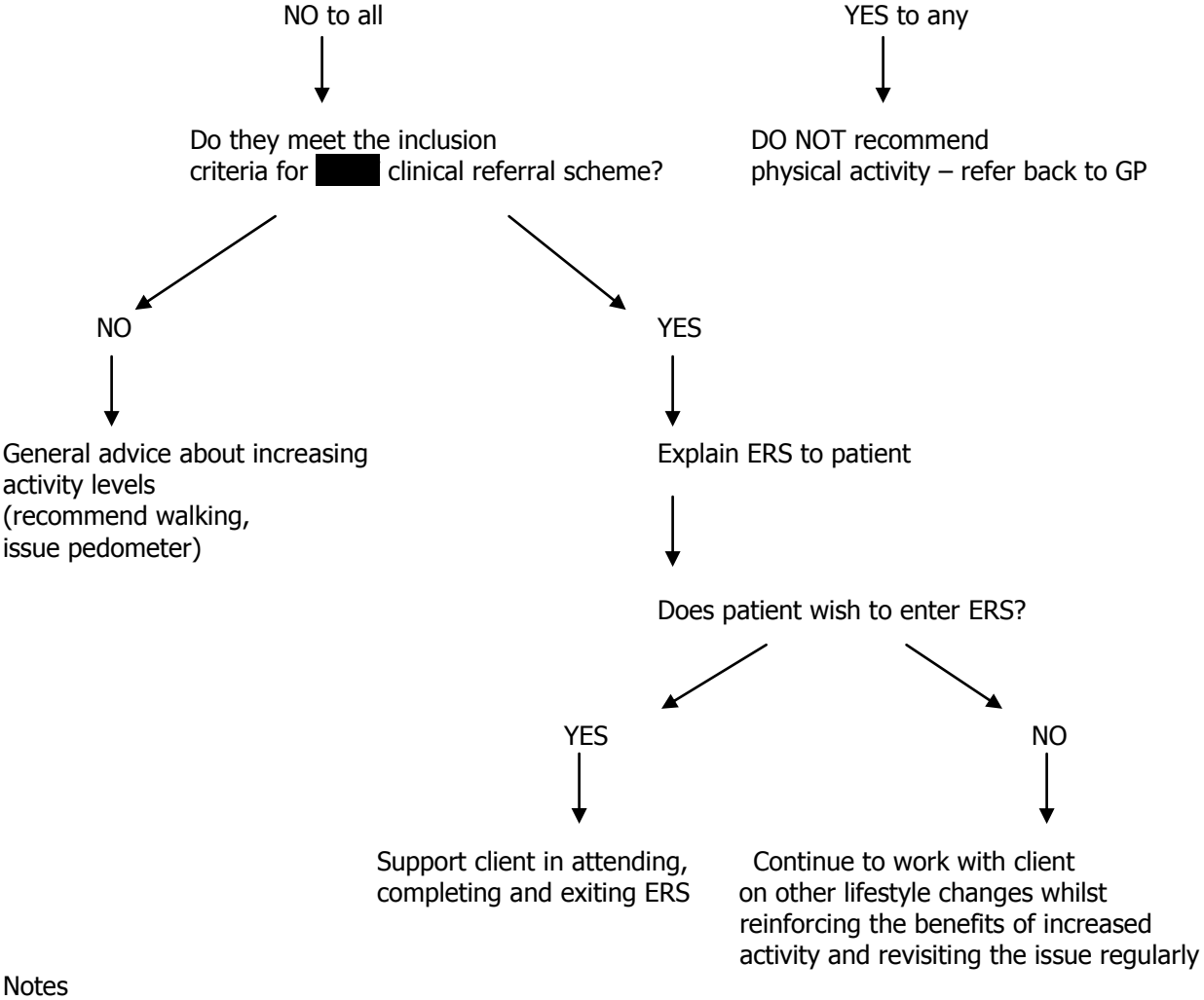

Self-Referral Guidelines: For Weight Reduction or Healthy Eating Advice
Client advised or wants to lose weight? Requires healthy eating advice?
Health MOT
Refer to Screening Tool
Co-morbidity excl high blood pressure & high cholesterol
No
Yes
BMI > 39Kgm2
BMI < 39Kgm2
Seen dietitian within past year?
PHA not able to see:
No dietetic service available.
(Provide general healthy eating leaflet, FSA)
Collect data from client
•Gender
• Initials,
•Ethnicity,
•Age,
•Post code.
(this will be used to build a case for the need for service provision)
See client
Yes
No
Ask client for name and tel no of dietitian.
• Contact dietitian about client.
•See client.
Ask client to go back to GP or PN to refer to dietitian.
Follow up client to support in seeing dietitian.
Any disease specific questions from client, refer them to GP, PN or dietitian.
Any client with anxieties around food and body image should be referred to GP, irrespective of BMI

Self-referral guidelines / flowchart and screening tool for physical activity

Screening Tool

[redacted] adapted PAR-Q

Has your doctor ever said that you should not do physical activity?
Do you feel pain in your chest when you do physical activity?
In the past month have you had chest pain when not doing physical activity?
Do you lose balance because of dizziness?
Do you have any medical condition that could be made worse by an increase in physical activity?
Are you recovering from any illness/surgery or is there any other reason why you should not do physical activity?



Notes

From the PHA review a very low percentage of clients are asking for support to increase their physical activity. One reason for this could be that people (80% ADNFS) perceive themselves as active enough to achieve health benefits whilst in reality less than a third of people are. So do we need to raise awareness about what physical activity is required to achieve health benefits (i.e. 5 x 30 mins moderate intensity per week), also do they know what moderate is? They can break it down into 10 minute slots.

Around 40% of [redacted] are sedentary (do less than 30 minutes of physical activity per week), these people can gain the most benefit from becoming more active, even if they do not increase activity enough to meet 5 x 30 mins, any increase is better than no increase. For example decreasing the amount of time they spent sitting.

SECTION D

SYSTEMATIC REVIEW COMPETENCE

The Effectiveness of Community Interventions for Preventing Smoking in Young People.

ABSTRACT

Background

It is increasingly being recognised that as with many health behaviours, smoking is affected by a range of influences including personal, social, political and economical influences. This has led to the development of community-wide programs to prevent smoking in young people. However, developing effective community programs remains a challenge.

Objectives

To investigate the effectiveness of community interventions compared with no intervention and also the effectiveness of community interventions compared with other single component interventions (e.g. school-based programmes), in influencing the smoking behaviour of young people.

Search strategy

Electronic searches were conducted using the OVID and EBSCO platform from the dates September 2002 to December 2010. OVID databases included: CDSR, ACP Journal Club, DARE, CCTR, CLCMR, CLHTA, CLEED, Ovid MEDLINE(R), British Nursing Index, Global Health, EMBASE-PS. EBSCO databases included: CINAHL, E-Journals, International Bibliography of the Social Sciences, PsycARTICLES, Psychology and Behavioral Sciences Collection, PsycINFO. References of selected studies were also searched along with conducting general internet searches and hand searches of studies.

Selection criteria

Studies which consisted of i) controlled trial randomising communities, geographical regions or school districts and ii) controlled trials without randomisation, allocating communities, geographical regions or school districts were included. Those studies not reporting baseline characteristics were excluded.

Data collection and analysis

Two researchers independently assessed the quality of the studies using a quality assessment form. Scores were then compared and any discrepancies in ratings were resolved through consensus. Studies were combined using qualitative narrative synthesis.

Main results

Six studies did not meet all of the inclusion criteria. In total six studies were included in the review. All six studies used a controlled trial, with five using random allocation of schools or communities. Five of the six studies compared community interventions with no intervention or standard care. Of these, three showed effectiveness of community interventions with significantly lower rates of smoking prevalence being reported. One study investigated community interventions versus single component intervention (school-based) versus standard care. This study showed effectiveness for the community intervention with significantly lower smoking prevalence being reported for male participants.

Conclusion

Results are promising for the use of community interventions but there needs to be greater methodological quality and further studies that are conducted outside of the school environment.

BACKGROUND

Research has shown that many children start to experiment with cigarettes during early adolescence. 9% of 11 years olds have tried smoking and this figure increases to 55% of 15 year olds (The National Health Service [NHS] Information Centre, 2009). Overall around two thirds of smokers will have commenced smoking before the age of 18 years (Office for National Statistics, 2008). Hence adolescence is considered a significant time period in the development of a smoking habit. Fortunately smoking rates have been decreasing in recent years, with the current prevalence of regular smoking at 6% for 11-15 year olds. The rate is higher for girls at 8%, compared with 5% of boys (The NHS Information Centre, 2009).

Many initiatives have been developed over the years in an effort to help prevent smoking among young people, with the idea that if smoking is prevented during adolescence it is unlikely to occur after that (United States Department of Health and Human Services, 1994). These include primary prevention programmes, which are aimed at discouraging experimentation. The majority of these have been conducted in school-based settings. Early interventions focused primarily on educating on long-term health effects, which were found to have little or no effect on smoking behaviour (Killen, 1985). Later interventions were designed to equip adolescents with skills to resist social pressures but their effects were modest and tended to be short lived (Flay et al, 1989; Hansen, 1992). More recent results regarding effectiveness have been mixed (Thomas & Perera, 2006).

It is increasingly being recognised that that as with many health behaviours, smoking is affected by a range of influences, including personal, social, political and economical influences. Therefore, it is argued that preventive strategies must be part of wider multi layered societal approaches to smoking rather than operated in isolation (Youdan &

Sandford, 2003). This has led to the development of more community-wide programs, which attempt to address the social environment in which young people take up smoking. These programs consist of the involvement of different organisations such as schools, youth centres, parents and other community organisations engaging in a variety of tasks, such as addressing societal attitudes to smoking and access to tobacco products. Such programs are often extensions to school-based programmes in an attempt to have a more far reaching tobacco prevention scheme. Initiatives vary in the extent to which they emphasise community involvement in planning of the intervention, with some being conducted through community groups emphasising a principle of 'ownership' or 'partnership' in promoting health (Sowden & Stead, 2003). Although there can be great diversity between community programs the general consensus is to reach the masses in the community and to provide structures that create an environment that perpetually supports an ethos of non-smoking and cessation (Schofield et al., 1991).

Research regarding the effectiveness of community interventions is currently limited. Sowden and Stead conducted a systematic review into community interventions for preventing smoking in young people in 2003 and Muller-Riemenschneider et al. (2008) conducted a literature review into the long-term effectiveness of behavioural interventions (including school, community and multi-sector based interventions) to prevent smoking among children and youth.

In the review conducted by Sowden and Stead (2003) they defined community interventions as "co-ordinated, widespread programmes in a particular geographical area (e.g. school districts) or region or in groupings of people who share common interests or needs, which support non-smoking behaviour." (Sowden & Stead, 2003; pg.3) and discovered some limited support for the effectiveness of such interventions. They discovered community interventions to represent a diverse set of interventions. For example, in some studies, youth

prevention of smoking was part of larger community-wide programmes to reduce cardiovascular disease in all age groups or target cancer prevention whereas in other studies it was part of a larger program targeting tobacco, alcohol and drug use. With regards to results, of twelve studies which compared community-wide interventions with no intervention controls, two studies (which were both part of larger community-wide cardiovascular disease prevention programmes) reported differences in smoking prevalence with one showing smoking prevalence lower in the intervention group than the control group, and the other vice versa. Next, four studies compared community-wide interventions with controls receiving a school-based intervention only, with only one study reporting statistically significant differences in self-reported smoking between intervention and control groups. However, this difference was not apparent when objective measures of smoking status involving Carbon Monoxide testing were used. Next, of those studies comparing community interventions only with school and community based interventions, no differences in smoking rates between the two groups were found, although smoking prevalence decreased in both groups from baseline to follow-up. Finally, one study which compared a community and mass media component with a mass media component only, found smoking rates to increase in both groups. Hence a variation in results for community interventions is apparent. The authors also reported difficulties in evaluating community-based interventions due to the heterogeneity between studies regarding interventions, communities, participants and measurements of outcome. Also the importance of establishing adequate control groups was discussed by using the community as opposed to individuals as the unit of the analysis. It was recognised the latter was often done to increase power of the study and hence led to erroneous positive findings.

Muller-Riemenschneider et al. (2008), in their review of long-term behavioural interventions found stronger evidence for the effectiveness of community and multi-sector based interventions as opposed to solely school-based interventions.

Overall since Sowden and Stead (2003) conducted their systematic review there have been wide developments in community interventions for preventing smoking in young people, such as the use of youth advocates and youth health councils. Therefore it was decided to conduct an update of Sowden and Stead's systematic review from the time period of September 2002 (as their search ended in September 2002) to the year 2010. Although Muller-Riemenschneider et al. conducted a review in 2008, they only included community interventions based on behavioural principles, which excluded social and cognitive approaches. Also they only focused on long-term effectiveness and their review was not a systematic review.

Hence the purpose of this review is to explore the effectiveness of community interventions in preventing smoking in young people, using the definition of community interventions outlined by Sowden and Stead (2003).

OBJECTIVES

To provide an update of Sowden and Stead's (2003) review of effectiveness of community interventions for preventing smoking in young people and to include greater searches of psychological journals and broaden the search terms used than in the original review. The following questions will be addressed:

i) The effectiveness of community interventions compared with no intervention in influencing the smoking behaviour of young people.

ii) The effectiveness of community interventions compared with other single component interventions (e.g. school-based programmes) in influencing the smoking behaviour of young people.

METHODS OF THE REVIEW

Criteria for considering studies for this review

Types of studies

Studies which evaluated the effectiveness of community interventions in the prevention of smoking in young people, using one of the following designs were included in the review:

1) Controlled trial randomising communities, geographical regions or school districts.

2) Controlled trials without randomisation, allocating communities, geographical regions or school districts. This inclusion of quasi-experimental studies resulted from the wide variation in research design with community interventions.

Those studies not reporting baseline characteristics of groups were excluded.

Types of participants

Studies with participants aged less than 25 years were included in the review, which coincides with the United Nations' definition of 'youth' for statistical purposes (The United Nations, 2011).

Types of interventions

Studies focusing on community interventions for preventing smoking among young people were included in the review. 'Community interventions' were defined according to the definition outlined by Sowden and Stead (2003), as: "multi-component, co-ordinated, widespread programmes supporting non-smoking behaviour in particular geographical regions or location".

Types of outcome measures

Primary measure

The primary measure for this review was smoking status of participants. This could be obtained through objective measures (saliva thiocyanate levels, alveolar CO) and/or self-reported measures. Participants could be classified as smokers or non-smokers in a number of ways, including being classed as smokers according to daily, weekly or monthly smoking or smoking at any point in lifetime. Wherever possible the strict definition of smoking involving any history of cigarette use was used.

Studies which did not include a primary measure of outcome were excluded.

Secondary and process measures

Secondary measures included factors, such as intentions to smoke, attitudes towards smoking and knowledge of smoking. Process measures included the wider effects of the intervention, such as attendance of stop smoking events and fidelity demonstrated by those involved.

Search methods for identification of studies

Search terms and databases

Prior to commencing the review internet searches were made, for example, on the Cochrane Tobacco Addiction Group database and the original authors were contacted to ensure there were no upcoming reviews on the subject area. The original authors were also contacted for full search terms used in their review. However, own search terms were also developed to broaden the search. These combined terms relating to smoking, young people and community-wide interventions. Some databases from the original review were no longer available or had substantial changes to the database interface, which meant that the strategies were no longer relevant. Additional databases to the original review were also searched and these included psychological databases, such as PsycINFO.

Searches were conducted using OVID and EBSCO platforms with specification of dates from September 2002 to December 2010. The following databases were searched using the OVID platform:

CDSR

ACP Journal Club

DARE

CCTR

CLCMR

CLHTA

CLEED

Ovid MEDLINE (R)

British Nursing Index

Global Health

EMBASE-PS

The following databases were searched using the EBSCO platform:

CINAHL

E-Journals

EconLit

International Bibliography of the Social Sciences

PsycARTICLES

Psychology and Behavioral Sciences Collection

PsycINFO

Regional Business News

An example of a search strategy used for OVID is as follows. Other examples for OVID and EBSCO are provided in appendix 1:

OVID Database: CDSR, ACP Journal Club, DARE, CCTR, CLCMR, CLHTA, CLEED, Ovid MEDLINE(R), British Nursing Index, Global Health, EMBASE-PS

Search Strategy:

1 (smok$ or nicotin$ or cigar$ or tobacco).ti. (116199)

2 (young or school$ or student$ or pupil$ or youth$ or teen$ or underage$ or preschool or girl$ or boy$ or juvenile$ or kid$ or adoles$ or child$ or minor$).ti. (1009891)

3 (prevent$ or abstain$ or start$ or abstinence$ or develop$ or commenc$ or tak$ up or initiat$).ti. (651759)

4 (communit$ or neighbo$ or soci$ or local$ or county or state$ or citizen$ or outreach or inter$).ab. (4636851)

5 (model$ or intervention$ or pilot or health promotion or program$ or project$ or initiative$ or treatment$ or support$ or therap$ or approach$ or schem$ or stud$ or trial$ or field$ or multi$ or mass$ or strateg$ or way$ or method$ or procedure$).ab. (9405508)

6 4 and 1 and 3 and 2 and 5 (896)

7 limit 6 to yr="2002 - 2010" [Limit not valid in DARE; records were retained] (575)

8 remove duplicates from 7 (324)

9 from 8 keep 4,7,20,23,40,54,56,61,70,76,85,106,131,142,208,211,221,255,289,291,304,316,330,324(24)

Other search methods

Other search methods included reviewing reference lists of studies identified, hand searching studies and conducting internet searches. Only studies published in the English language were sought.

Study selection

RK selected studies for inclusion into the review by checking over titles and abstracts of the studies. If this could not be determined from the abstract the full article was obtained for further review. The search strategy initially identified 798 abstracts to review, from which 31 were selected for further assessment through quick review of title, abstract and descriptors. Of these 22 were identified as being potentially suitable for inclusion in the review and full copies of the articles were sought.

Excluded studies and included studies

From the total of 22 studies, 10 were excluded due to not meeting the inclusion criteria. This included not having a control group and not reporting baseline characteristics. Refer to appendix 2 for a list of excluded studies and reason for exclusion. Duplicates of the same authors' and collaborative authors' published studies reporting the same intervention were also excluded, with the most representative of the studies being included (NB: these studies were sometimes referred to when the included study referenced them in order to access further data). Six studies were duplicates (refer to appendix 3 for list).

In total six studies were included in the review (refer to reference list for included studies).

Data extraction strategy

Data was extracted from the included studies by using a data extraction form, which included items such as the objective of the study, participant details and procedure details (refer to appendix 4 for examples).

Methodological quality assessment

Quality assessment criteria for the studies were developed. These included criteria, such as the theoretical basis of the intervention and the process of randomisation. The following quality assessment ratings were assigned to each of the criterion:

1. Process of randomisation: Controlled trial with computerised random assignment or controlled trial with computerised random assignment after matching = 3 points;

Controlled trial with non-computerised random assignment or controlled trial with non-computerised random assignment after matching = 2 points; Controlled trial with unspecified random assignment or controlled trial with unspecified random assignment after matching = 1 point; Controlled trial with non random assignment = 0 points

2. Comparability at baseline: Comparable at baseline (not significant imbalances between control and intervention groups or imbalances addressed through statistical adjustment)= 1 point; Not comparable at baseline/Not indicated= 0 points
3. Details of participants: Description of participants provided (e.g. age, sex, ethnicity, SES) = 1 point; No description of participants provided = 0 points
4. Power analysis: Power analysis conducted = 1 point; Power analysis not conducted/Not stated = 0 points
5. Theoretical basis of intervention: Psychological basis provided = 2 points; Other theoretical basis provided = 1 point; No theoretical basis provided = 0 points
6. Details of procedure: Step by step guide of procedure = 2 points; Some description of procedure = 1 point; Barely any description of procedure = 0 points
7. Supervision of intervention: Supervised by a researcher/qualified practitioner = 1 point; Not supervised by a researcher/qualified practitioner = 0 points; No information provided = 0 points
8. Follow-up: Follow-up period of < 1 year = 3 points; Follow-up period of ≤ 1 year = 2 points; Follow-up period of ≤ 6 months = 1 point; Post-test end of intervention only = 0 points
9. Robustness of primary outcome measures: Combination of biochemical validation and self-report measures = 3 points; Biochemical validation only = 2 points; Self-report measures only = 1 point

10. Inclusion and robustness of secondary and/or process outcomes: Inclusion of secondary and/or process outcomes derived from reliable and valid measures = 2 points; Inclusion of secondary and/or process outcomes not derived for reliable and valid measures = 1 point; No inclusion of secondary and/or process outcome measures = 0 points
11. Unit attrition rates: Attrition rates ≤ 10% = 3 points; Attrition rates ≤ 50% = 2 points, Attrition rates > 50% = 1 point, Attrition not stated = 0 points
12. Individual participant attrition rates: Attrition rates ≤ 25% = 4 points; Attrition rates ≤ 50% = 3 points; Attrition rates ≤ 75% = 2 points; Attrition rates > 75% = 1 point; Attrition not stated = 0 points
13. Appropriate statistical analysis used according to data: Appropriate statistical analysis used = 1 point; Appropriate statistical analysis not used = 0 points
14. Adjustment made for clustering: Adjustment made for clustering = 1; Adjustment not made for clustering/Not indicated = 0

The studies were scored by two reviewers, RK and GA. A maximum score of 28 could be allocated to each study according to the quality assessment ratings. Studies with a score between 28 and 24 were regarded as high quality, those between 23 and 15 as medium quality and those 14 and under as low quality. RK and GA firstly independently scored the studies. Then ratings between both reviewers were compared. A combined total of 115 points for all of the studies was awarded by each of the reviewers. There was a discrepancy in scores for two of the six studies (RK awarded a total of 19 points and GA 18 points to one and RK awarded 18 points and GA 19 points to another). These discrepancies occurred over the process of randomisation and details of the procedure and were the result of oversight as opposed to difference in opinion. Hence consensus was reached promptly through discussion.

DESCRIPTION OF STUDIES

Detailed information about each of the six included studies is provided in the data extraction forms for each study in appendix 4.

All six studies investigated the effectiveness of community interventions (multi-component in nature), which were developed to prevent young people aged less than 25 years from smoking. Studies were published from years 2002 to 2009, with interventions having commenced from years 1987 to 2004. The studies were conducted in the USA (D'Onofrio et al., 2002; Perry et al., 2003; Winkleby et al, 2004), Australia (Schofield et al., 2003), India (Perry et al., 2009) with one study taking place in six different countries of Finland, Portugal, Spain, The Netherlands, UK and Demark (De Vries et al., 2005). In total 49,023 participants were recruited from a total of 74 community clubs and 325 schools.

Characteristics of communities

The communities in which the interventions took place varied between studies. Urban settings included the two large cities of Delhi and Chennai in India (Perry et al., 2009), the Hunter and Taree school districts of New South Wales in Australia (Schofield et al., 2003) and the San Francisco-San Jose area of northern California in the US (Winkleby et al, 2004). Another study conducted in California focused on 26 counties across the whole state so included more rural and small communities (D'onofrio et al., 2002). Other studies were conducted in a combination of rural and urban communities, including urban, suburban and rural areas of Minnesota in the US (Perry et al., 2003), the cities of Madrid and Barcelona in

Spain, two rural regions of Denmark, the city of Helsinki in Finland, five rural and urban regional health authorities in The Netherlands and two health authority regions in the UK (De Vries et al., 2005).

Characteristics of participants

Participant characteristics also varied between studies. Some studies commented on targeting high-risk groups, for example, focusing on participants in rural areas and small communities due to higher smokeless tobacco rates (D'Onofrio et al., 2002), selecting participants from urban settings due to tobacco use being particularly problematic for youth living in urban areas (Perry et al., 2009) and selecting youth from continuation high schools due to high smoking rates in these schools (Winkleby et al., 2004).

Characteristics of interventions

Objectives

The objectives of the interventions varied among studies. Three studies focused specifically on preventing tobacco use among young people (Schofield et al., 2003; Perry et al., 2009; De Vries et al., 2005). The other three studies focused on prevention and reduction of tobacco use (Perry et al., 2003; D'onofrio et al, 2002; Winkleby et al., 2004). One study also additionally focused on marijuana use, alcohol use, violence and victimisation (Perry et al., 2003) and another on smokeless tobacco (D'onofrio et al., 2002).

Specific components

Community components in the intervention varied between studies. One study consisted of community leaders being actively involved in developing and implementing aspects of the intervention, such as organising neighbourhood action teams and creating and facilitating extracurricular activities for students (Perry et al., 2003). Other studies involved participants working with different community bodies such as retailers, city councils, medical workers (such as dentists and pharmacists), youth clubs and sports organisations (Winkleby et al., 2004; De Vries et al., 2005; D'onofrio et al., 2002). One study had less intensive input from community members, which just included sending a letter to tobacco retailers (Schofield et al., 2003). Another study offered additional optional community components consisting of poster display contests in the community, creating a prevention commercial, working with community agencies on tobacco use prevention, organising a tobacco-free day and starting a cessation group (D'onofrio et al., 2002).

The majority of studies included community components as an addition to school-based components. (Winkleby et al., 2004; Perry et al., 2009, De Vries, 2005; Perry et al., 2003; Schofield et al., 2003). Only one study, which took place in community clubs, offered a school-based component as an optional component, which consisted of conducting a tobacco survey at school (D'onofrio et al., 2002). Another study also offered optional school-based components including drama sketches and poster competitions but this was in addition to a compulsory school-based component (Schofield et al., 2003).

Family components were also included with the majority of studies (Perry et al., 2009; Perry et al., 2003; D'onofrio et al., 2002; Schofield et al., 2003; De Vries et al., 2005). These included creating a tobacco use policy with families (D'Onofrio et al., 2002), having a discussion group and survey with parents with a follow-up element (Schofield et al., 2003), home team activities to be completed with parents (Perry et al., 2003) and distribution of parent smoking pamphlets (Schofield et al., 2003). The six countries involved in De Vries et

als' (2005) study varied in their degree of family involvement, for example, Spain only provided a brochure about the intervention to parents whereas Portugal also included parents meetings, surveys, newsletters, homework activities with parents and cessation support for parents.

Media components were included by some countries involved in De Vries et als' study (2005). Denmark had non-smoking commercials shown on television for two months and Portugal had articles in local newspapers on World No Smoking Day.

Primary outcomes

Primary outcomes involved indicators of cigarette use for all the studies. These indicators varied between studies. Three studies referred to cigarette use over approximately the last month (D'onofrio et al., 2002; Perry et al., 2009; Schofield et al., 2003; Perry et al., 2003) and one also over the last week (Schofield et al., 2003). One study assessed ever smoking and weekly smoking status and then categorised participants into non-smokers, experimental smokers, daily smokers, etc (De Vries et al., 2005). The final study asked 'how many cigarettes do you smoke now?' and then categorised participants as non-smokers, experimental/light smokers or regular smokers accordingly (Winkleby et al., 2004).

Secondary/process outcomes

All the studies measured secondary outcomes in addition to the primary outcome measure of smoking status. The majority of studies measured behavioural intentions to smoke, which was stated by four studies (D'onofrio et al., 2002; Perry et al., 2009; Perry et al., 2003; De Vries et al., 2005). Three studies measured knowledge and attitudes (D'Onofrio

et al., 2002; Schofield et al., 2003; Perry et al., 2009) and self-efficacy (Perry et al., 2009; De Vries et al., 2005; Winkleby et al., 2004). Finally, two studies measured perceptions (Winkleby et al., 2004; Schofield et al., 2003).

Three studies also measured process outcomes. These included fidelity of implementation, positive adaptations, program leader characteristics, member attendance and club size (D'onofrio et al., 2002), level of involvement in community advocacy (Winkleby et al., 2004) and fidelity and participation (Perry et al., 2009).

Duration

Duration of interventions varied between the studies. The shortest duration was five months (D'Onofrio et al., 2005) and the longest two and a half years (De Vries et al., 2005). Four studies described periods of two years, which consisted of four months each over two school years (Perry et al., 2009), four semesters over two school years (Winkleby et al., 2004) two complete school years (Perry et al., 2003) and two complete calendar years (Schofield et al., 2003).

Methodological quality

Out of the six studies, two were scored as high quality, one which got 23 out of 28 points (Winkleby et al, 2004) and the other 22 out of 28 points (D'onofrio et al., 2002). The rest of the four studies were deemed as medium quality, with 19 points (Perry et al., 2009), 18 points (De Vries et al., 2005), 17 points (Perry et al., 2003) and 16 points (Schofield et al., 2003).

With regards to scoring for each of the criteria, firstly five of the six studies were randomised controlled trials. One study which involved trials in six countries only conducted randomised controlled trials with four of those countries (De Vries et al., 2005). Method of randomisation was only specified by one study which involved the tossing of a coin (Winkleby et al., 2004). Unit of allocation consisted of schools for the majority of studies, with only one study using youth clubs (D'Onofrio et al., 2002). Random allocation took place after matching in three studies. In one study, youth clubs were matched on the basis of geographic region and club size (D'onofrio et al., 2002), in another, schools were matched according to type of school, such as private vs. governmental and coeducational vs. girls only vs. boys only (Perry et al., 2009) and in the final study, schools were matched on socio-economic measures, drug (including tobacco) use and size (Perry et al., 2003).

Three studies ensured comparability at baseline (D'onofrio et al., 2002; Perry et al., 2009; De Vries., 2005). The other three either did not mention comparability (Schofield et al., 2003), indicated slight differences in characteristics (Winkleby et al., 2004) or did not indicate sufficient comparability by only providing information on comparability of ethnicity of participants (Perry et al., 2003).

All the studies reported participant characteristics consisting of sex, age and/or school grade. Five studies also included ethnicity (D'onofrio et al., 2002; Schofield et al., 2003; Perry et al., 2003; Winkleby et al., 2004) and four studies also included indicators of socioeconomic status (Schofield et al., 2003; Perry et al., 2009; Winkleby et al., 2004, De Vries et al., 2005).

Power analysis was conducted by one study (De Vries et al., 2005). Two studies (Perry et al., 2003; Schofield et al., 2003) alluded to sufficient statistical power but provided no details of testing.

Five of the six studies provided a theoretical basis for the interventions. Four of these were based on elements of psychological theory. For example, three studies described the Social Influences approach, either in isolation (D'onofrio et al., 2002) or included as part of the Attitude Social Influences Self-Efficacy (ASE) model which originated from the Theory of Reasoned Action but also incorporated elements from Social Cognitive Theory, The Transtheoretical Model and Precaution Adoption Model (De Vries et al., 2005) or in combination with Social Cognitive Theory, Action Theory and Conceptual Theory (Perry et al., 2009). One study was based on Social Learning and Empowerment Theory (Winkleby et al., 2004). The final study which was not based on psychological theory was based on Community Organisation Theory (Schofield et al., 2003). One study did not provide a theoretical basis (Perry et al., 2003).

Detailed step-by-step guide of procedure was provided by all of the studies. All the interventions in the studies were supervised by a researcher or qualified practitioner. With regards to delivery, the majority of interventions were delivered by trained school staff members consisting primarily of teachers (De Vries et al., 2005; Schofield et al., 2003), teachers with trained peer leaders and field staff (Perry et al., 2009) or teachers with trained police officers (Perry et al., 2003). Research staff delivered the intervention in one study (Winkleby et al., 2004) and pairs of trained youth and adult volunteers in another (D'onofrio et al., 2002).

With regards to follow-up, the longest period of follow-up was two years (D'onofrio et al., 2002), followed by six months (Winkleby et al., 2004). The remainder of the studies only measured post-test outcomes at the end of the intervention.

Primary outcome measure of smoking status was obtained through self-report measures by all the studies, with only one study also including biochemical validation

(Winkleby et al., 2004). Secondary and process outcomes were obtained from reliable and valid measures in all studies.

All the studies provided attrition rates, which involved unit attrition and individual participant attrition rates. With regards to unit attrition, only three studies had unit drop out, and of these attrition was less than 10% attrition for all three (Schofield et al., 2003; Perry et al., 2009; De Vries et al., 2005). With regards to individual participant attrition, two studies reported ≤ 25% (Winkleby et al., 2004; Perry et al., 2003), three studies ≤ 50% (Schofield et al., 2003; Perry et al., 2009; D'onofrio et al., 2002) and one study ≤ 75% (De Vries et al., 2005).

Appropriate statistical analysis was used by all of the studies and given that the design of the study involved random allocation of units, all of the studies made adjustments for clustering apart from one study (Schofield et al., 2003).

RESULTS

Attempts to identify similarities between studies were made in order to conduct a meta-analysis. However, there was a great deal of heterogeneity between all the studies in regards to intervention content, length and intensity, study variables including design, measures of smoking behaviour (including primary and secondary) and length of follow up, which meant this was not possible. Instead a narrative synthesis will be provided of the studies.

Narrative synthesis

In total the majority of studies compared community interventions against no intervention (or standard care (Perry et al., 2009; De Vries et al., 2005; Winkleby et al., 2004, Schofield et al., 2003; D'onofrio et al., 2002). One study compared community interventions against a single school-based component against a control (Perry et al., 2003).

Table 1 below provides an overview of the effectiveness of the interventions in each of the studies, with regards to both primary and secondary measures. Significance levels, effect sizes (ES) and odds ratios (OR) with 95% confidence intervals (CI) have been reported where available. This is followed by a discussion of the results for each of the studies.

***Table 1*: Effectiveness of Interventions on Primary and Secondary Outcomes**

	Primary outcome	**Secondary outcomes**				
		Intentions	**Knowledge**	**Self-efficacy**	**Attitudes**	**Perceptions**
Perry et al. 2009 (2 year intervention) IG (n= 6365) CG (n=7698)						
Mid-point (one year) into intervention	Not significant	Significant*	Significant**	Significant*	Significant*	
Post-test data at end of 2 year intervention	Significant*	Significant**	Significant*	Significant*	Significant*	
De Vries et al. 2005 (30 month intervention) Mid-point (one year) into intervention						
-Overall	Not significant	Not significant		Not significant	Not significant	
-Finland	Significant*** (OR: 0.61/CI:0.46-0.80)	Not significant		Not significant	Not significant	
-Portugal	Not significant	Not significant		Significant*	Not significant	
-UK	C. Significant	C. Significant		C. Significant	Not significant	
-Spain	Significant* (OR: 0.63/CI: 0.41-0.94)	Significant***		Significant*	Significant**	
-The Netherlands	Not significant	Not significant		Not significant	Not significant	
-Denmark	C. Significant	Not significant		Not significant	Not significant	
Mid point (two years) into intervention IG (n=5318) CG (n=5433)						

-Overall -Finland -Portugal -UK -Spain -The Netherlands -Denmark Post-test data at end of 30 month intervention IG (n=4536) CG (n=4746) -Overall -Finland -Portugal -UK -Spain -The Netherlands (non native) (native) -Denmark	Not significant Significant* (OR: 0.76/CI: 0.57-1.00) Not significant Not significant Not significant C. Significant Not significant Significant* (OR: 0.89/CI: 0.80-0.99) Not significant Significant** (OR: 0.56/ CI: 0.37-0.84 Not significant Not significant Significant** (OR: 0.34/ CI: 0.15-0.78 C. Significant Not significant	Not significant Not significant Significant* ES: 0.12 Not significant Not significant C. Significant Not significant Not significant Not significant Significant** ES:0.17 Significant* ES:0.09 Not significant Not significant Not significant		Not significant Not significant Significant* ES: 0.15 Not significant Not significant C. Significant Not significant Significant** ES:0.04 Not significant Significant* ES: 0.16 Significant * ES: 0.08 Not significant Not significant Significant* ES: 0.17	Significant* ES: 0.06 Significant* ES: 0.09 Significant* ES: 0.10 Not significant Significant*** ES: 0.17 Not significant Not significant Significant*** ES: 0.08 Not significant Significant** ES: 0.16 Not significant Not significant Not significant Not significant	
Winkleby et al. 2004 (two year intervention) IG (n=367) CG (n=431) Post-test data at end of intervention: Overall Regular smokers Non-smokers Light smokers 6 month follow-up Regular smokers Non-smokers	 Significant*** Not significant Not significant Significant*** Not significant			 Significant***		 Significant***

Light smokers	Not significant					
D'onofrio et al. 2002 (5 months intervention) (n=1114)						
4 months post-test follow up	Not significant	Significant*	Significant*		Significant*	
2 years post-test follow up	Not significant	Not significant	Not significant		Not significant	
Schofield et al. 2003 (2 year intervention) IG (n=1007) CG (n=845)						
Post-test data at end of intervention	Not significant		Significant***		Not significant	Not significant
Perry et al. 2003 (2 year intervention) Post-test data at the end of the intervention IG (n=2635) CG (n=2108) Single (n=2518)						
Vs Control						
Boys	Significant*	Significant*				
Girls	Not significant	Not significant				
Vs Single Component						
Boys	Significant	Significant*				
Girls	Not significant	Not significant				

***Note*: Significant Indicates in Favour of the Intervention and C. Significant as Counter-Significant Against the Intervention**
IG: Intervention Group CG: Control Group *p<.05 **p<.01 ***p<0.001 ES: Effect Size OR: Odds Ratio CI: 95% Confidence Intervals

Community interventions versus no intervention (or standard care)

Five of the six studies compared community interventions with no intervention or standard care (Winkleby et al., 2004; Perry et al., 2009; De Vries et al., 2005; D'onofrio et al., 2002; Schofield et al., 2003).

Perry et al. (2009)

The first was the study by Perry et al. (2009), which investigated whether a two year community intervention called project MYTRI, which was school-based, would prevent and reduce tobacco use rates. Tobacco use consisted of the use of cigarettes, bidis (small hand rolled cigarettes) and chewing tobacco. The participants were 6th and 8th grade students. A total of 32 schools participated, with 16 schools receiving the intervention and 16 schools serving as a delayed intervention control, which meant they received the intervention at the end of the trial. The intervention consisted of behavioural classroom curricula, school posters, a parental involvement component, and peer led activism outside of the classroom.

Primary outcomes

Data obtained at midpoint during the two year intervention (after one year) did not indicate a significant change in tobacco use, which decreased in both the control and intervention group over time. However, results at the end of the two year intervention found that overall tobacco use increased by 68% in the control group and decreased by 17% in the intervention group. There were significant between-group differences in the trajectories of cigarette smoking (which referred to cigarette use over the last 30 days) ($p<.05$), bidi smoking ($p<.01$), and any tobacco use ($p<.04$). The intervention was also more successful in reducing tobacco use rates among girls and 6th graders than among boys and 8th graders.

Secondary outcomes

Data collated at mid-point of the intervention indicated that participants in the intervention condition had fewer intentions to smoke tobacco in the next year ($p = 0.02$). Marginally significant differences were noted in their intentions to smoke in college ($p = 0.08$) or as an adult ($p = 0.08$). Also participants in the intervention condition also made significant gains in 12 of the 14 psychosocial risk factors. They (i) had better knowledge about the health effects of tobacco ($p < 0.01$); (ii) believed that there were more negative social consequences to using tobacco ($p = 0.04$); (iii) had fewer reasons to use tobacco ($p < 0.01$); (iv) had more reasons not to use tobacco ($p = 0.03$); (v) were less socially susceptible to chewing tobacco ($p = 0.04$) and smoking tobacco ($p = 0.03$); (vi) perceived fewer peers and adults around them smoked tobacco ($p < 0.01$) or chewed tobacco ($p < 0.01$); (vii) felt that tobacco use was not acceptable, especially among their peers ($p < 0.01$); (viii) were more confident in their ability to advocate for tobacco control ($p = 0.03$); (ix) were more knowledgeable about tobacco control policies ($p < 0.01$); and (x) supported these policies too ($p = 0.04$). No significant differences between study conditions in changes in refusal skill self-efficacy ($p = 0.66$) or normative expectations were observed ($p = 0.25$).

Data collated at the end of the intervention showed there were significant differences in the trajectories of students' intentions to smoke ($p<.01$) and chew tobacco ($p<.03$) over time, with the intervention group decreasing their intentions more than the control group. Intentions to smoke increased by 5% in the control group and decreased by 11% in the intervention group and intentions to chew tobacco decreased by 12% in the control group and by 28% in the intervention group. There were also significant differences in students' social, environmental and intrapersonal factor trajectories over time. For example, there were between group differences with respect to knowledge of the health effects of tobacco use, reasons to use and not use tobacco, perceived prevalence of chewing tobacco and smoking, normative beliefs regarding tobacco use, advocacy skills self-efficacy, knowledge of tobacco

control policies and social susceptibility to chewing tobacco use (all $p<0.05$). All of these differences were in the hypothesised direction with the exception of perceived prevalence of chewing tobacco use and smoking, for which the trajectories of intervention groups increased more than the control groups.

Process outcomes

At the end of the intervention, programme activities were implemented in all 16 intervention schools, participation rates were high, and levels of fidelity to the intervention were good. In the first year, 88% of all curriculum activities were completed, and in the second year, 93% of activities were completed. All posters were routinely hung in the schools and classrooms and during the first year, at least 76% of postcards were delivered to parents. In the first and second years, 678 and 761 students, respectively, were trained to be peer leaders and 153 and 133 teachers respectively, were trained to supervise and assist peer leaders and to structure the classroom activities. The peer leaders organised an interschool activity in each of the cities, with 3569 students attending in the first year (67% of the intervention cohort) and 4652 students attending in the second year (81%).

De Vries et al. (2005)

The next study was conducted by De Vries et al. (2005) which involved investigating whether a two and a half year intervention, called ESFA (European Smoking prevention Framework Approach), which was school based, would prevent uptake of smoking in six countries; Finland, Portugal, UK, Spain, The Netherlands and Denmark. A total of 235 schools participated, with 111 in the intervention group and 124 in the control group, which comprised of standard care. The intervention targeted four levels; the individual adolescent level, school level, parental level and out of school level, and varied between countries.

Primary outcomes

With regards to primary outcomes, data on never smokers becoming ever smokers was captured and data on never smokers becoming weekly smokers was also obtained. The latter will be discussed because this data was captured at all the follow up points. Data that was available on the former is provided in the results section of the data extraction table in appendix 4.

Firstly, data captured 12 months into the 30 month intervention (T2), did not show overall significance in the countries with regards to non-smokers becoming weekly smokers from baseline (T1). However, results in specific countries found a significant effect in favour of the intervention. Using Odds Ratios (OR) with 95% Confidence Intervals (CI), it was found that in Finland, 15.9% of the T1 non-smokers in the control group had started smoking at T2 compared to 11.2% of the intervention group (OR=0.61/ CI: (0.46-0.80)/ $p<0.001$). A significant effect in favour of the intervention was also found in Spain whereby 8.9% of the T1 non-smokers in the control group had started smoking at T2 compared to 5.8% of the intervention group (OR=0.63/ CI: (0.41-0.94)/ $p<0.05$). A counter significant effect was found in Denmark where 10.3% of the T1 non-smokers in the control group had started smoking at T2 compared to 12.9% of the intervention group (OR= 1.63/ CI: (1.06-2.52)/ $p<0.05$). A counter significant effect was also found in the UK whereby although 9% of the T1 non-smokers in the control group had started smoking at T2 compared to also 9% of the intervention group (OR=1.27/ CI: 1.00-1.62)/ $p<0.05$), logistic regression analysis controlling for confounding factors revealed a slight counter-productive effect.

Data obtained 24 months into the intervention (T3) also did not find an overall significant effect in the countries with regards to non-smokers becoming weekly smokers, whereby 18.8% of the T1 non-smokers in the control group had started smoking at T3 compared to 18.4% of the intervention group (OR=0.97/ CI: (0.69-1.08)/ $p<0.62$). However, a significant effect in favour of the intervention was found in Finland whereby 30.1% of the

T1 non-smokers in the control group had started smoking at T3 compared to 24.8% of the intervention group (OR=0.76/ CI: (0.57-1.00)/ $p<0.05$). A counter significant effect was found in The Netherlands where 14.6% of the T1 non-smokers in the control group had started smoking at T3 compared to 19.6% of the intervention group (OR=1.39/ CI: (1.10-1.76)/ $p<0.01$).

Finally, data obtained at 30 months on completion of the intervention (T4) did find an overall significant effect in favour of the intervention, whereby 23.4% of the T1 non-smokers in the control group had started smoking at T4 compared to 21.9% of the intervention group (OR=0.89/CI: (0.80-0.99)/ $p<0.03$). A significant effect in favour of the intervention was observed in Portugal, where 12.4% of the T1 non-smokers in the control group had started smoking at T4 compared to 7.9% of the intervention group (OR=0.56/ CI: (0.37-0.84)/ $p<0.01$). A significant effect in favour of the intervention was also found in The Netherlands for non-native adolescents, with 11.4% new weekly smokers compared to 19.9% in the control group (OR=0.34/CI: 0.15-0.78/$p<0.01$). However, a counter significant effect was found for native adolescents in The Netherlands, whereby there were 19.0% new weekly smokers in the comparison group compared to 24.0% new smokers in the intervention group (OR=1.29/CI:1.02-1.63)/ $p<0.04$).

Secondary outcomes

T2 data illustrated no overall significant differences between the control and intervention groups in regards to attitudes, self-efficacy and intentions to smoke. However, data for specific countries showed, firstly with regards to attitudes, in Spain the intervention group was significantly less convinced of the advantages of smoking than the control group. Adjusted mean scores for the control group (C) and Intervention group (E) indicated, (C 1.12, E 0.41; $p<0.01$). Next, with regards to self-efficacy, in Spain the intervention group reported significantly higher scores on social self-efficacy (C 6.07, E 6.99; $p<0.01$) and stress self

efficacy (C 6.85, E 7.62; $p< 0.05$) than those from the control group. In Portugal the intervention group also reported significantly higher stress self efficacy scores than the control group (C 8.50, E 8.96; $p< 0.05$). In the UK a significant counter effect was found for social self-efficacy (C 6.83, E 6.27; $p< 0.01$), stress social efficacy (C 7.86, E 7.39; $p<0.01$) and situational self-efficacy (C 8.77 E 8.45; $p<0.05$). Finally, with regards to intentions to take up smoking in the next year, in Spain the intervention group had more negative intentions to smoke than those from the control group (C -1.19, E-1.44; $p< 0.001$). In the UK a significant counter-effect occurred, where the intervention group had significantly less negative intentions to smoke (C -1.88, E -1.75; $p<0.01$).

T3 data showing adjusted mean scores for the control group (C) and Intervention group (E) and effect size (ES), illustrated that overall in the countries there was only a significant difference between control and intervention groups regarding beliefs in the pros of smoking, with less of the intervention group believing in the pros of smoking (C 0.03, E -0.03; $p<0.05$; ES: 0.06).

With regards to specific countries, this effect was significant in Finland (C 0.04, E -0.05; $p<0.05$; ES: 0.09), Portugal (C 0.06, E -0.05; $p<0.05$; ES: 0.11) and Spain (C 0.09, E -0.08; $p<0.001$; ES: 0.17). However, there was also a significant difference in Portugal regarding beliefs in cons of smoking, with more of the control group believing in the cons (C -0.07, E 0.06; $p<0.05$; ES: 0.12). With regards to self-efficacy, there were significant differences in favour of the intervention in Portugal, where the intervention group showed more social self-efficacy (C -0.09, E 0.07; $p<0.001$; ES:0.16), situational self-efficacy (C -0.07, E 0.06; $p<0.05$; ES:0.13) and stress self-efficacy (C -0.09, E 0.07; $p< 0.01$; ES:0.15). In the Netherlands a significant counter effect occurred with situational self-efficacy (C 0.03, E -0.05; $p<0.05$; ES:-0.09). Next, with regards to intentions, the intervention group in Portugal had less intention to smoke in the next year than the control group (C 0.07, E -0.05; $p<0.05$;

ES: 0.12). In The Netherlands a significant counter effect occurred (C -0.04, E 0.07; $p<0.05$; ES: -0.11).

T4 data illustrated an overall significant difference in the countries between groups for beliefs regarding pros of smoking, with less of the intervention group believing in pros than the control group (C 0.04, E -0.04; $p<0.001$; ES: 0.08), and for social self-efficacy, with the intervention group indicating more social self-efficacy than the control group (C -0.02, E 0.02; $p<0.01$; ES: 0.04). In regards to data for specific countries, there was a significant difference in Portugal regarding beliefs in pros of smoking with less of the intervention group believing in the pros (C 0.10, E -0.08; $p<0.01$; ES: 0.17). The Portuguese intervention group also had significantly more beliefs in the cons of smoking than the control group (C -0.09, E 0.07; $p< 0.01$; ES: 0.16). However, Spain indicated a counter significant effect (C 0.06, E -0.05; $p< 0.05$; ES: -0.12). Next, with regards to social self-efficacy, there were significant differences in Denmark (C -0.09, E 0.11; $p<0.05$; ES: 0.18) Portugal (C -0.09, E 0.07; $p< 0.01$; ES: 0.16) and the UK (C -0.04, E 0.04; $p< 0.05$; ES: 0.08) in favour of the intervention. There were also significant differences for stress-self efficacy in Portugal (C -0.08, E 0.07; $p<0.05$; ES: 0.15) and situational self-efficacy in Denmark (C -0.08, E 0.10; $p< 0.05$; ES: 0.16) in favour of the intervention. Finally, with regards to intentions, both Portugal (C 0.10, E -0.08; $p< 0.01$; ES: 0.17) and the UK (C 0.05, E -0.04; $p< 0.05$; ES: 0.09) showed significantly less intention to smoke in the next year in the intervention group than the control group.

Overall it could be seen that in T2 there were no changes, in T3 there were significantly less beliefs in the pros of smoking in the intervention group, which was sustained into T4. Also in T4 there was significantly more social self-efficacy in the intervention group.

Winkleby et al. (2004)

The next study conducted by Winkleby et al. (2004) was also school-based and investigated whether a two year advocacy intervention aimed at high school students would prevent or reduce their tobacco use. A total of 20 high schools participated, with 10 high schools being assigned to the intervention group and 10 to the control group, which consisted of receiving an existing program about drug and alcohol abuse prevention. The advocacy intervention was designed to modify proximal influences on cigarette smoking, build awareness of distal environmental influences on smoking and engage youth in devising strategies to modify environmental influences on cigarette smoking.

Primary outcomes

Results from data obtained on completion of the intervention, showed there was a significant net change from baseline to the end of the intervention between treatment and control high schools for students who were regular smokers (smoking ≥ 1 pack per week) but not for students who were non-smokers (never smoked or former smokers) or light smokers (smoking < 1 pack per week). Regular smoking decreased 3.8% (SD 1.7) in treatment high schools and increased 1.5% (SD 1.6) in control high schools, with a significant net change of 5.3% ($p<.001$). Rates of non-smoking increased about 3.5% for both treatment (3.6% SD 3.4) and control high schools (3.4 SD 5.0). The significant net changes in regular smoking were consistent across the 5 intervention high schools.

Results at 6 month follow up post-intervention showed that the significant net change in regular smoking for the intervention versus the control high schools was maintained. Regular smoking decreased an additional 1% (SD 4.5) in intervention high schools. Overall rates of regular smoking in the intervention high schools were 25.1% at baseline, 21.3% after the intervention and 20.3% at the 6 month follow up assessment. In contrast, rates of regular smoking rates in the control high schools were similar across all 3 time points. Also when

examined at the individual level rather than at the high school level, 39% of intervention participants compared to 26% of the control participants who reported being regular smokers at baseline, reported being light or non-smokers at the 6 month follow-up assessment. There were no significant differences for those who reported being light smokers and non-smokers at baseline.

Secondary outcomes

There were significant net changes between treatment and control schools for three social cognitive constructs; perceived incentive value for creating a tobacco-free environment (0.4; $p<.001$), perceived self-efficacy to perform advocacy activities (0.2; $p=.004$) and outcome expectancies that advocacy activities would result in changes in students' environments (0.3; $p=.003$). All measures related to the three social constructs remained unchanged in the control high schools.

Process outcomes

There was a significant net change in involvement in community advocacy activities. For example, the mean number of community-advocacy activities that students were involved in during the preceding five months, increased from 0.9 to 4.0 in the intervention high schools and remained unchanged at 1.0 in the control high schools.

D'onofrio et al. (2002)

The study by D'onofrio et al was the only study based in youth clubs and investigated whether the five month intervention of Project 4-Health would prevent and reduce tobacco use (smokeless and cigarettes) in 4-H community club members (aged 10-14 years). A total of 72 clubs participated, which were assigned to either the intervention or control condition. The control comprised of a regular club meeting. The intervention consisted of a core set of five experience-based sessions which were complemented by "going further" activities to be

completed by members in their own time. Optional group projects taking place in the community and school were also offered.

Primary outcomes

The program did not show any significant effects on any of the six behaviours measured in the study, which included current cigarette use (over the last 30 days), in either post test 1 which was conducted 4 months post completion of the two year intervention or post test 2 which was conducted two years post completion of the intervention.

Secondary outcomes

With regards to secondary measures, effects were found at post test 1 on 7 of the 24 outcomes measures in favour of the intervention. Using program effect coefficients (EC) and 95% Confidence Intervals (CI), these included significant effects for the knowledge variables of perceived prevalence of use (EC: +.058; CI: +.21, + .095; $p < .05$), smokeless tobacco addictive (EC: +.168; CI: +.062, + .274; $p<.05$), and first use harmful (EC: +.166; CI: +.019, +.313; $p<.05$). They also included significant effects for the attitude variables of, ease of quitting (EC: +.154; CI: +.005, + .303; $p< .05$), tobacco companies target kids (EC: +.194; CI: +.051, + .337; $p<.05$) and smokeless safer than cigarettes (EC: +.234; CI: +.118, + .350; $p<.05$). Finally, they included effects on one behavioural intention variable of intentions to smoke cigarettes (EC: +.084; CI: +.023, + .145; $p<.05$).

However, at post test 2 none of the 24 program effect estimates were significant.

Process outcomes

Fidelity of program implementation varied by club from 43.0% to 85.3% with a mean fidelity of 67.3 % (SD=9.7). Program leaders added their own anecdotes to the curriculum about twice per session. Only 5.3% of members reported completing the going further activities. An average of 28.4 members (SD=12.5) and 14.2 adults (SD=7.7) attended meetings of program clubs. Program attendance was unrelated to post test outcomes and

despite the large number of exploratory analysis conducted no evidence was found that any process measures was related to post test outcomes.

Schofield et al. (2003)

The final study was a school-based approach and investigated whether the two year intervention of The Hunter Health Promoting Schools (HPS) programme would prevent cigarette smoking among year 7-8 students in public secondary schools. A total of 24 schools were assigned to the intervention or control group, which comprised of standard care (although control schools were offered support for other health-related issues by the project team and promised smoking specific support at the completion of the study period if they requested it). The intervention involved a minimum set of activities involving school and parental involvement and letters to tobacco retailers. Optional activities were also included.

Primary outcomes

Results obtained from data at the completion of the two year intervention demonstrated that the HPS program failed to improve smoking behaviour (indicated by smoking behaviour over the last week and last four weeks) over the 2 years (equal increase of 10% in both groups).

Secondary outcomes

The program was successful in improving smoking knowledge about smoking (relating to laws of cigarette sales to minors and safe levels of smoking) between pre and post test. At post test, 64% of the intervention group had the maximum knowledge score compared with 60% in the control group, representing a pre to post test increase of 12% in the intervention group versus 7% in the control group ($p=0.001$).

With regards to attitudes, the program was not successful in improving overall attitudes towards smoking. However, specifically positive attitudes to smoking decreased from pre- to post-test among smokers but not among non-smokers (p=0.01).

Community interventions versus single component interventions versus no intervention (or standard care)

One study investigated community interventions versus single component intervention versus standard care.

Perry et al. (2003)

The study by Perry et al. (2003) which was school-based, investigated the effectiveness of a two year community intervention consisting of the D.A.R.E. (Drug Abuse Resistance Education) Plus programme against a single component school-based two year intervention consisting of the D.A.R.E. programme, against a control, in preventing and reducing tobacco, alcohol, marijuana and multidrug use, violence and victimisation. Seventh grade students from 24 schools were allocated to either the two intervention or control groups, which consisted of a delayed program control, meaning these schools would also receive the intervention at the end of the trial.

The D.A.R.E. programme intervention consisted of a school-based curriculum involving skills in resisting influences to use drugs, focused on character building and citizenship skills. The D.A.R.E plus programme also incorporated a peer-led parental involvement classroom programme, youth-led extracurricular activities, community adult action teams and postcard mailings to parents.

Primary outcomes

Results derived from data taken at the end of the two year interventions found there were no significant differences between the D.A.R.E only intervention group and the control group compared to baseline.

However, there were significant differences among boys between the D.A.R.E. plus intervention and the control group with regards to tobacco, alcohol, multidrug use and victimisation, in favour of the D.A.R.E. plus intervention. With regards to specifically current smoking (cigarette smoking over the last 30 days), boys in the D.A.R.E. plus intervention group were significantly less likely to show increases in current smoking (n=1381, growth rate 0.18, SE 0.05) ($p \leq .02$) than those in the control group (n=1093, growth rate 0.31, SE 0.05).

There were also significant differences among boys between the D.A.R.E. plus intervention and the D.A.R.E. only intervention groups, with regards to tobacco use and violence, in favour of the D.A.R.E. plus intervention. With regards to specifically current smoking, boys in the D.A.R.E plus intervention group were significantly less likely to show increases in current smoking (n=1381, growth rate 0.18, SE 0.05) ($p \leq .08$) than those in the D.A.R.E. only intervention group (n=1269, growth rate 0.28, SE 0.05).

There were no significant behavioural differences among girls.

Secondary outcomes

Neither boys nor girls had significant differences between the D.A.R.E only intervention group and the control group with regards to tobacco behavioural intentions.

However, there were significant differences among boys between the D.A.R.E. plus intervention and the control group with regards to tobacco behavioural intentions, in favour of the D.A.R.E. plus intervention. Boys in the D.A.R.E. plus intervention showed less tobacco behavioural intentions (n=1381, growth rate 0.68, SE 0.11) ($p<.04$) than those in the control group (n=1093, growth rate 0.96, SE 0.12).

There were also significant differences among boys between the D.A.R.E. plus intervention and the D.A.R.E. only intervention groups, with regards to tobacco behavioural intentions, in favour of the D.A.R.E. plus intervention. Boys in the D.A.R.E plus intervention group showed less tobacco behavioural intentions (n=1381, growth rate 0.68, SE 0.11) ($p \leq .04$) than those in the D.A.R.E. only intervention group (n=1269, growth rate 0.95, SE 0.11).

DISCUSSION

Overall four of the six studies reported statistically significant differences in smoking prevalence between the intervention and control groups in favour of the intervention (Winkleby et al., 2004; Perry et al., 2003; Perry et al., 2009; De Vries et al., 2005). Interventions in these four studies were a minimum of 2 years in duration, ranging from two years to 30 months. The one study out of these which also conducted a follow up found a significant effect 6 months post intervention (Winkleby et al., 2004). Two of the studies focused specifically on cigarette smoking, one also investigated chewing tobacco use and another also investigated wider drug, alcohol use and violence. Also two studies focused specifically on prevention of use (Perry et al., 2009; De Vries et al., 2005) and the other two on prevention and reduction of use (Perry et al., 2003; Winkleby et al., 2004). Three of the studies were based on psychological theory, with one's theoretical basis unstated and they were all school-based. All multi-component community interventions in the studies included, school, familial and community components with one study also employing media components for two of the countries involved in the study.

With regards to secondary outcome measures, five of the six studies indicated that the interventions were effective in influencing specific secondary outcomes. These included

intentions (Perry et al., 2009; Perry et al., 2003), knowledge (Schofield et al., 2003; Perry et al., 2009), self-efficacy (Perry et al., 2009; De Vries 2005; Winkleby et al., 2004), perceptions (Winkleby et al., 2004) and attitudes (De Vries et al., 2005; Perry et al., 2009).

Overall methodological quality of the studies was not very high. Some of the main methodological shortcomings involved lack of detail on process of randomisation, lack of biochemical validation of smoking status and lack of statistical power analysis. Also only two studies conducted follow-ups post the intervention. One of these studies found significant effects at six months follow-up (Winkleby et al., 2004) but the other study did not. One of the possible reasons for this maybe because of the logistical problems with conducting longer-term follow-ups with students once they leave the educational establishment. Process outcomes were only measured by three of the studies and it can be argued that these are particularly important to include in such studies. This is because as community interventions are multi-layered and generally complex in nature, process outcomes can provide useful insight particularly when interventions are not shown to be effective. It can be deduced whether the actual intervention or whether ways in which the intervention was implemented may be responsible for the results. With regards to analysis, in contrast to the original review conducted by Sowden and Stead (2002), it was discovered that the unit of allocation was adequately accounted for in the analysis with the majority of studies.

Overall it appears that results for community interventions in preventing smoking use in young people is promising but there needs to be greater methodological quality. Also it was noted that the majority of the studies were conducted in schools, with only one study conducted in the community in youth clubs. Although the intervention in this youth club based study was not shown to be effective, it can be argued that there is further need for such studies to be conducted within the community. This is because the generalisability of findings is limited by studies predominantly taking place in schools. Young people that do not attend

schools may also be at greater risk of smoking and are not being captured by such studies. Also the involvement of communities within the interventions themselves with regards to development and implementation was also limited in the studies and this may be an area of further development.

CONCLUSION

Limitations of review

Overall the length of follow-up in the majority of studies was short which did not allow for assessment of longer-term effectiveness. Also many of the studies were school-based which limits the generalisability of findings to young people generally. A greater use of biochemical validation is needed to validate self-reports of smoking status. Also it can be argued that further studies that are carried out in the UK need to be conducted as there was only one in this review which was part of a larger Europe-based study.

Implications for practice

Overall the use of comprehensive multi-layered community interventions, incorporating school, family and community components for the prevention of youth smoking looks promising. Longer duration of interventions as opposed to shorter duration appears preferable in addition to those based on psychological theory. Building upon existing programmes that have been shown to be effective is recommended as well as developing

areas which have not been explored as much, such as greater involvement of the community in development and implementation.

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De Vries, H., & Dijk, F., & Wetzels, J., & Mudde, A., & Kremers, S., & Ariza, C., & Vitoria, P.D., & Fielder, A., & Holm, K., & Janssen, K., & Lehtovuori, R., & Candel, M. (2005). The European Smoking Prevention Framework Approach (ESFA): effects after 24 and 30 months. *Health Education Research. 21*(1), 116-132.

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Perry, C.L., & Stigler M.H., & Arora, M., & Reddy, K.S. (2009). Preventing tobacco use

among young people in India: project MYTRI. *American Journal of Public Health. 99*(5), 899-906.

Schofield, M.J., & Lynagh, M., & Mishra, G. (2003). Evaluation of a health promoting schools program to reduce smoking in Australian secondary schools. *Health Education Research. 18*(6), 678-692.

Winkleby, M.A., & Feighery, E., & Dunn, M., & Kole, S., & Ahn, D., & Killen, J.D. (2004). Effects of an advocacy intervention to reduce smoking among teenagers. *Archives of Pediatrics Adolescent Medicine. 158,* 269-275.

APPENDICES

Appendix 1

Search Strategy

OVID SEARCHES
Database: CDSR, ACP Journal Club, DARE, CCTR, CLCMR, CLHTA, CLEED, Ovid MEDLINE(R), British Nursing Index, Global Health, EMBASE-PS
Search Strategy:
---
1 (smok$ or nicotin$ or cigar$ or tobacco).ti. (116199)
2 (young or school$ or student$ or pupil$ or youth$ or teen$ or underage$ or preschool or girl$ or boy$ or juvenile$ or kid$ or adoles$ or child$ or minor$).ti. (1009891)
3 (prevent$ or abstain$ or start$ or abstinence$ or develop$ or commenc$ or tak$ up or initiat$).ti. (651759)
4 (communit$ or neighbo$ or soci$ or local$ or county or state$ or citizen$ or outreach or inter$).ab. (4636851)
5 (model$ or intervention$ or pilot or health promotion or program$ or project$ or initiative$ or treatment$ or support$ or therap$ or approach$ or schem$ or stud$ or trial$ or field$ or multi$ or mass$ or strateg$ or way$ or method$ or procedure$).ab. (9405508)
6 4 and 1 and 3 and 2 and 5 (896)
7 limit 6 to yr="2002 - 2010" [Limit not valid in DARE; records were retained] (575)
8 from 7 keep 4,7,20,23,40,46,54,56,61,70,106,142,208,210,221,255,259,289,304,309,316,344,373,392,460 (25)
9 (communit$ or youth group$ or youth club$).ab. (261979)
10 1 and 9 and 2 (792)
11 limit 10 to yr="2002 - 2010" [Limit not valid in DARE; records were retained] (518)
12 from 11 keep 8-9,17,125,234,437 (6)
13 (young or youth or child$ or adoles$ or teen$).ti. (731680)
14 (smok$ or tobacco or cigar$).ti. (91483)
15 communit$.ti. (104274)
16 13 and 15 and 14 (124)
17 limit 16 to yr="2002 - 2010" [Limit not valid in DARE; records were retained] (62)
18 from 17 keep 3,37 (2)

MEDLINE(R), British Nursing Index, Global Health, EMBASE-PS
Search Strategy:
---
1 (smok$ or nicotin$ or cigar$ or tobacco).ti. (116199)
2 (young or school$ or student$ or pupil$ or youth$ or teen$ or underage$ or preschool or girl$ or boy$ or juvenile$ or kid$ or adoles$ or child$ or minor$).ti. (1009891)
3 (prevent$ or abstain$ or start$ or abstinence$ or develop$ or commenc$ or tak$ up or initiat$).ti. (651759)
4 (communit$ or neighbo$ or soci$ or local$ or county or state$ or citizen$ or outreach or inter$).ab. (4636851)
5 (model$ or intervention$ or pilot or health promotion or program$ or project$ or initiative$ or treatment$ or support$ or therap$ or approach$ or schem$ or stud$ or trial$ or field$ or multi$ or mass$ or strateg$ or way$ or method$ or procedure$).ab. (9405508)
6 4 and 1 and 3 and 2 and 5 (896)
7 limit 6 to yr="2002 - 2010" [Limit not valid in DARE; records were retained] (575)
8 from 7 keep 4,7,20,23,40,46,54,56,61,70,106,142,208,210,221,255,259,289,304,309,316,344,373,392,460 (25)
9 (communit$ or youth group$ or youth club$).ab. (261979)
10 1 and 9 and 2 (792)
11 limit 10 to yr="2002 - 2010" [Limit not valid in DARE; records were retained] (518)
12 remove duplicates from 11 (321)
13 from 12 keep 8-9,17,125 (4)

EBSCO SEARCHES

#	Query	Limiters/Expanders	Last Run Via	Results
				1
S6	S1 and S4	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - Business Source Complete;CINAHL;E-Journals;EconLit;International Bibliography of the Social Sciences;PsycARTICLES;Psychology and Behavioral Sciences Collection;PsycINFO;Regional Business News	91
S5	S1 and S4	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - Business Source Complete;CINAHL;E-Journals;EconLit;International Bibliography of the Social Sciences;PsycARTICLES;Psychology and Behavioral Sciences Collection;PsycINFO;Regional Business News	153
S4	S2 and S3	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - Business Source Complete;CINAHL;E-Journals;EconLit;International Bibliography of the Social Sciences;PsycARTICLES;Psychology and Behavioral Sciences Collection;PsycINFO;Regional Business News	66726
S3	TI school$ or TI pupil$ or TI preschool	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - Business Source Complete;CINAHL;E-Journals;EconLit;International Bibliography of the Social Sciences;PsycARTICLES;Psychology and Behavioral Sciences Collection;PsycINFO;Regional Business News	241512
S2	TI young or TI child$ or TI adoles$ or TI minor$ or TI kid$ or TI juvenile$ or TI boy$ or TI girl$ or TI underage$ or TI teen$ or TI youth$ or TI student$	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - Business Source Complete;CINAHL;E-Journals;EconLit;International Bibliography of the Social Sciences;PsycARTICLES;Psychology and Behavioral Sciences Collection;PsycINFO;Regional Business News	902378
S1	TI smok$ or TI nicotin$ or TI cigar$ or TI tobacco	Search modes - Boolean/Phrase	Interface - EBSCOhost Search Screen - Advanced Search Database - Business Source Complete;CINAHL;E-Journals;EconLit;International Bibliography of the Social Sciences;PsycARTICLES;Psychology and Behavioral Sciences Collection;PsycINFO;Regional Business News	31797

Appendix 2

Excluded Studies and Reason for Exclusion

Name of study	Reason for exclusion
Aldinger, C., & Zhang, X.W., & Liu, L.Q., & Pan, X.D., & Yu, S.H., & Jones, J., & Kass, J., (2008). Changes in attitudes, knowledge and behaviour associated with implementing a comprehensive school health program in a province of China. *Health Education Research*. 23(6), 1049-1067.	No control group
Berenson, G.S. (2010). Cardiovascular health promotion for children: a model for Parish (County)-wide program (implementation and preliminary results). *Preventive cardiology*. 13(1), 23-28.	No control group
Bowen, D., & Orlandi, M., & Lichtenstein, E., & Cummings, K., & Hyland, A. (2002). Intervention effects on youth tobacco use in the community intervention trial (COMMIT). *Tobacco Control. 11*(4), 382.	No control group
Jason, L.A., & Pokorny, S.B., & Adams, M., & Nihls, A., & Yeon Kim, H., & Hunt, Y. (2010). Cracking down on youth tobacco may influence drug use. *Journal of Community Psychology*. 38(1), 1-15.	Inadequate control group
O'Riordan, D.L., & Sutton, N., & Haro-Arvizu, P.(2005). A community-based approach to tobacco prevention: Hawaii's youth taking on the tobacco industry. *Hawaii Medical Journal. 64*, 310-312.	No control group
Reinert, B., & Carver, V., & Range, L.M. (2004). Anti-tobacco messages from different sources make a difference with secondary school students. *Journal of Public Health Management Practice. 10*(6), 518-523.	No baseline characteristics reported, No control group
Smith, T.M., & Talley, B., & Hubbard, M., & Winn, C. (2008). Evaluation of a tobacco prevention program for children: ToPIC. *Journal of Community Health Nursing*. 25(4), 218-228.	No control group
Tingen, M.S., & Waller, J.L., & Smith, T.M.,& Baker, R.B., et al. (2006).Tobacco prevention in children and cessation in family members. *Journal of the American Academy of Nurse Practitioners. 18*(4), 169-179.	No control group
Wilson, N., & Minkler, M., & Dasho, S., & Wallerstein, N., & Martin, A.C. (2008). Getting to social action: the youth empowerment strategies (YES!) project. *Health Promotion Practice*. 9(4), 395-403.	No control group
Wood, L.J., & Rosenberg, M., & Clarkson, J., & Phillips, F., & Donovan, R.J., & Shilton, T. (2009).Encouraging young western Australians to be smarter than smoking. *American Journal of Health Promotion*. 23(6), 403-411.	No control group

Appendix 3

Duplicate Studies

Duplicate for De Vries et al. (2005)
De Vries, H., & Mudde, A., & Leijs, I., & Charlton, A., & Vartiainen, E., & Buijs, G., & Clemente, M.P., & Storm, H., & Navarro, A.G., & Nebot, M., & Prins, T., & Kremers, S. (2003). The European Smoking Prevention Framework Approach (ESFA): an example of integral prevention. *Health Education Research. 18*(5), 611-626.
De Vries, H., & Mudde, A., & Kremers, S., & Wetzels, J., & Uiters, E., & Ariza, C., & Vitoria, P.D., & Fielder, A., & Holm, K., & Janssen, K., & Lehtovuori, R., & Candel, M. (2003). The European Smoking Prevention Framework Approach (ESFA): Short-term effects. *Health Education Research. 18*(6), 649-663.
Ariza, C., & Nebot, M., & Tomas, Z., & Gimenez, E., & Valmayor, S., & Tarilonte, V., & De Vries, H. (2008). Longitudinal effects of the European smoking prevention framework approach (ESFA) project in Spanish adolescents. *European Journal of Public Health. 18*(5), 491-497.
Vartiainen, E., & Pennanen, M., & Haukkala, A., & Dijk, F., & Lehtovuori, R., & De Vries, H. (2007).The effects of a three-year smoking prevention programme in secondary schools in Helsinki. *European Journal of Public Health. 17*(3), 249-256.
De Vries, H., & Engels, R., & Kremers, S., & Wetzels, J., & Mudde, A. (2003). Parents' and friends' smoking status as predictors of smoking onset: findings from six European countries. *Health Education Research. 18*(5), 627-636.
Duplicate for Perry et al. (2009)
Stigler, M.H., & Perry, C.L., & Arora, M., et al. (2007). Intermediate outcomes from project MYTRI: mobilizing youth for tobacco-related initiatives in India. *Cancer epidemiology, biomarkers and prevention. 16*, 1050-1056.

Appendix 4

Data Extraction Tables for Each Study

***Title:** Curtailing tobacco use among youth: evaluation of project 4-Health
***Authors:** D'Onofrio et al. (2002)
***Programme name**: Project 4-Health
***Objective**: Development, implementation and evaluation of Project 4-Health, a program aimed at preventing and reducing tobacco use (smokeless and cigarettes) among 4-H community club members.
***Country:** USA
***Site:** Community-based youth groups called 4-H community in 26 counties across state of California including in rural and small communities
***Reason for site selection**: ST use higher in rural areas and small communities than in large metropolitan regions

***Methodology:**
-Design: Randomised controlled trial. Clubs were matched into pairs based on geographic region and club size. One club from each pair was randomly assigned to the program condition or control condition.
-Sample size:
-Originally from:
Clubs: 78 4-H community clubs with a minimum enrolment of 20 members each.
Individual participants: 1,967 club members (intervention = 977 (62 excluded in evaluation due to lack of parental consent)/control = 990 (52 excluded in evaluation due to lack of parental consent)
-Participated:
Clubs: 72 4-H community clubs (two clubs were eliminated due to poor matches and four clubs due to inability to recruit volunteers to deliver the educational program so evaluation was only based on 72 clubs located in 24 counties and matched into 36 pairs)
Individual participants: 1, 853 club members (intervention = 938/ control = 915)
-Retained
Clubs: 72 4-H clubs
Individual participants:
1,641 of 1,853 members (88.6%) completed pre-test
Post-test1 completed by 1,305 out of 1,641 (79.5%)
Post-test 2 completed by 1,114 out of 1,641 (67.9%)
-Attrition:
Clubs: 0
Individual participants: 32.1% dropped out from pre-test to post-test 2 (1114 left out of 1,641)
-Power analysis
Not conducted
-Participants:
Out of 1853 club members who were aged 10-14 years:
Sex: 1,066 (57.5%) were girls and 787 (42.5%) were boys
Ethnicity: Racial ethnic composition 89.4% White non-Hispanic, 6.5% Latino, 1.1% Asian/Pacific Islander, 0.6% Native American, 0.3% African American and 2.1% missing data.
Average age: was 12.11 years
-Procedure:
Duration: 5 months January – May 1998 (intervention delivered to the 36 clubs in the program condition during the five monthly community club meetings)
Follow up: post-test 1: 4 months post-test, post-test 2: 2 years post-test
Intervention components: The intervention consisted of a core set of five experience based sessions.
1. Each club member will recognise that (a) Most fellow members hold a negative image of people who smoke cigarettes and use smokeless tobacco (ST); (b) The vast majority of young people do not smoke or chew tobacco. The club will identify tobacco use as a topic of interest.
2. Each 4-H club member will become aware of key facts about tobacco. Club members and their families will create a policy about tobacco use.
3. Each 4-H member will recognise that tobacco advertisements promote tobacco use and ignore negative effects.
4. Each 4-H member will practice effective ways of communicating a decision about tobacco. The club will support effective communication skills.
5. Each 4-H member will identify two things that he or she has learned, two things that he or she feels, and two things that he or she will do about tobacco use. The club will focus on the four "H's" of the 4-H emblem, reinforcing the importance of working to promote health by using one's head, heart, and hands.

These were complemented by "going further" activities to be completed by members in their own time. Also creating a tobacco use policy with families. Optional group projects taking place in the community and school were also offered (poster display contests in the community, creating a prevention commercial, working with community agencies on tobacco use prevention, organising a tobacco-free day and starting a cessation group)
-Control: Regular club meeting
-Theoretical basis of intervention: Social influences approach based on social inoculation theory (McGuire, 1964)
-Intervention delivered by: pairs of trained youth and adult volunteers
-Intervention supervised by: research staff
-Outcome measures
-Primary outcome: Self-reported smoking status - Behaviour variable on survey consisting of cigarette current use (over the last 30 days)
-Primary outcome measures: Self-reported smoking status (Computer assisted telephone interviews)
-Secondary outcomes: Knowledge, attitudes, intentions
-Secondary outcome measures: Computer assisted telephone interviews, mail survey, questionnaire
-Robustness of secondary outcome measures:

To the extent possible standardised questions recommended by a NCI working group were used, however the wording of some questions had to be simplified to accommodate the cognitive levels of younger 4-H community club members. In addition new questions were developed to assess variables unique to this study. Questions measuring the same concept were combined into composite variables, and Cronbach's alpha was calculated for the measures. All but two of the composite variables (perceived prevalence of use, social benefits of using) exhibited adequate internal consistency ($\alpha \geq .60$).Because no measures of tobacco use with proven psychometric properties were available and because tobacco use had not previously been studied in California 4-H, all questions were extensively pilot-tested.

-Process outcomes: Process data were collected to examine the relationships of program implementation and contextual club features (club size and member attendance) to program outcomes and to help refine the program for subsequent dissemination.
-Process outcome measures: In experimental clubs, the duration of each program session also was recorded, and these sessions were audio-taped by the program leaders using recorders and tapes supplied by the project. In addition, project staff conducted two structured, on-site observations of each program club and analysed the products of group activities completed during the sessions observed.

***Analysis**
-Tests used: A Statistical Analysis System Interactive Matrix Programming Language (SAS/IML) macro, GEE, was used that estimates regression parameters for clustered, longitudinal data, treating the correlation between observations within individuals and within clusters as a nuisance. A primary advantage of this approach compared to other methods for analysing hierarchical designs is that the program can model discrete (binary) and continuous response data. Separate analyses were conducted for the subsamples of participants who completed the pre-test and each post-test to minimize the problem of participant attrition. Because only 67.8% of the youths who completed the pre-test completed both post-tests, participant attrition would have been more substantial had complete data from all three measurement waves been required to qualify for the data analysis. Three sets of analyses were conducted. First, for each post-test subsample, the pre-test data were analysed to determine whether the experimental conditions were initially equivalent. Pre-test measures included the following 7 variables in addition to the 19 pre-test variables: age, gender, single parent, parental tobacco use, sibling tobacco use, cigarette smoking by friends, and ST use by friends. Second the pre-test data also were analysed separately for each post-test subsample to determine whether the experimental conditions were affected by participant attrition. This analysis used program condition, post-test completion, and the interaction of these variables as factors. A significant effect for post-test completion would provide evidence for limited external validity, or generalisability. A significant interaction would provide evidence for limited internal and external validity. Finally, to examine program effectiveness, the 24 post-test measures were analysed with the GEE procedure using program condition as a factor and the corresponding pre-test variable, where available, as a covariate. The Type I error rate was set at .05 for each analysis.
-Adjustments for clustering: Yes
The generalised estimating equation (GEE) approach to fitting population-averaged models was selected as GEE uses regression analyses to account and control for clustering effects.
-Comparability at baseline:
Yes: the pre-test data were analysed to determine whether the conditions were initially equivalent and testing indicated they were.
-Attrition bias and missing data: Tested for attrition bias (see tests used above). Attrition rates were

comparable for program and control groups. Within the program sample, 76.3% of pre-test participants provided data at Post-test 1, and 77.2% of pre-test participants provided data at Post-test 2. Comparable percentages within the control sample were 83.1% and 78.3%, respectively. Neither program-control difference was significant, suggesting that no bias was introduced into the experimental design due to loss of study participants.

***Title:** Evaluation of a Health Promoting Schools Program to Reduce Smoking in Australian Secondary Schools
***Authors:** Schofield et al. (2003)
***Programme name**: Health Promoting Schools (HPS)
***Objective**: To investigate the effectiveness of a 2 year collaborative community-based Health Promoting Schools (HPS) intervention in lowering the uptake of smoking and improving knowledge and attitudes among the cohort of students in intervention schools compared with control schools after controlling for pre-test smoking and other confounders.
***Country:** Australia
***Site:** Public secondary schools in Hunter and Taree school districts of New South Wales in Australia
***Reason for site selection**: None stated

***Methodology:**
-Design: Randomised controlled trial.
Sample size:
-Originally from:
Schools: 31 secondary schools
-Participated:
Schools: 24 secondary schools (due to financial and practical constraints) randomly selected from a population of 31 schools Intervention = 12 / Control = 12)
Individual participants: recruited at pre-test = 4841 (intervention = 2573/ control = 2268)
-Retained
Schools: 22 schools (Intervention = 12/ Control = 10)
Individual participants: 1852 completed post-test (after matching pre post data) which was 38% of pre-test sample) (Intervention = 1007/control = 845)
-Attrition
-Schools: 8% (2 out of 24 schools)
-Individual participants: 50 % (48% from intervention and 52% from control)
-Power analysis
Not conducted (Financial and practical constraints limited the number of selected schools to 24, a number which provides adequate design integrity and consistent with approach taken with COMMITT study in the US).
-Participants:
-Sex: Of the 1852 participants, 1011 (55%) were female and 841 (45%) males
-Ethnicity: 1361 (73%) parents both Australian, 204 (11%) one parent Australian, 287 (15%) other
-School grade: Year 7-8 students
-SE status: Fathers occupation (1-2 is high status, 3-4 is middle status, ≥5 is low status and 0 is no occupation) 1-2 = 133 (7%)/ 3-4 = 648 (35%)/ ≥5 = 720 (39%)/ 0 = 40 (2%)/ Missing = 311 (17%)
-Procedure:
-Duration: 2 years
-Follow up: post test data collected at end of two year intervention
-Intervention components: a minimum set of activities involving school and parental involvement and letters to tobacco retailers: i)ensure curriculum covers smoking effects (all 12) ii) distribute parent smoking pamphlet (all 12) iii) school smoking policy implemented (10) iv) tobacco retailer letters distributed (10) v) discussion group/survey conducted with parents (10) vi) Follow up action from discussion group/survey (7) vii) Training of SRC/peer leaders to deal with smoking issues (4).
Schools were also encouraged to undertake additional health promotion activities of their own choice, some of which included drama skits performed by students and poster competitions to promote World No Tobacco Day. The project team also provided a range of activities for the intervention schools such as training workshops, regular newsletters, quarterly reports and information resources such as computer interactive programs supplied to schools for defined periods of time for use by students in school libraries.
-Control: Optional delayed control (control schools were not offered any of the resources or actions to reduce smoking but were offered smoking support at the completion of the study).
-Theoretical basis of intervention: Community Organisation Theory
-Intervention delivered by: School staff trained as liaison officers
-Intervention supervised by: research staff (Surveys were completed in classrooms under supervision of teaching and research staff).

-Outcome measures
-Primary outcome: Smoking status via question on survey and retrospective diary of 'have you smoked in the last week' and 'have you smoked in the last four weeks'
-Primary outcome measures: self-reported smoking status on survey (smokers kept a retrospective diary which specified amount of smoking from a single puff to whole cigarettes)
-Secondary outcomes: Attitudes (towards smoking and school - positive perceptions of the school health environment were assessed by 17 questions, such as: `Teachers and parents try hard to make the school a healthy place', coded using a four-point scale from `strongly disagree' to `strongly agree'/ students were asked 20 questions about their attitudes towards smoking, using a four-point response scale from `strongly agree' to `strongly disagree'. Fourteen items measured positive perceptions about smoking, such as: `People who smoke are usually more popular than non-smokers', and six items measured negative perceptions (reverse scaled), such as: `Smoking can harm your health'.)
Knowledge about smoking (Students were asked about the laws relating to sale of cigarettes to minors and what they think is a safe level of smoking). Influences on smoking (to determine peer attitudes, students were asked: `Do your friends think that smoking cigarettes is: a cool thing to do; an uncool thing to do; neither cool nor uncool; or don't know?' Parental attitudes were assessed by asking: `What are the rules about smoking in your home?' Finally, they were asked their expectations about future smoking).
-Secondary outcome measures: Survey
-Robustness of secondary outcome measures: Inter-item reliability for each factor was assessed using Cronbach's a coefficients for standardised variables.
-Process outcomes: None

***Analysis**
-Tests used: Multivariate analyses examined intervention effect for the main outcome (post test smoking behaviour), controlling for pre-test smoking status, school and other confounders.
Exploratory factor analysis using principal components method and varimax rotation was performed on the 20 `attitude to smoking' items and separately on the 17 items measuring `attitudes to school'. Items which cross-loaded on several factors were eliminated. Items with a factor loading of 0.5 and above on one factor were retained. Inter-item reliability for each factor was assessed using Cronbach's a coefficients for standardised variables. Kaiser's measure of sampling adequacy (MSA) estimated the degree of inter-correlations among items. Attitudes to smoking. Two factors measuring `perceived positives' (10 items) and `perceived negatives' (four items) of smoking were confirmed at both pre- and post-test, keeping 14 of the original 20 items. The factors accounted for at least 44% of total variance. Sampling adequacy was 0.86, indicating that factor analysis was appropriate. Attitudes to school. For `attitudes to school' items, four factors were confirmed at both pre and post-test, which included 13 of the original 17 items. The factors were interpreted as `healthy school' (five items),`support for sun protection' (three items), `student involvement' (three items) and `barriers to smoking' (two items). They explained 59% of total variance; the Kaiser measure of sampling adequacy was 0.83. Factor scores for both scales were used in further analysis.
-Adjustments for clustering: No: For the test of intervention effect, had planned to use a cluster-based multilevel analytic method. However, preliminary analysis of variability between and across schools revealed that the cluster effect of schools was relatively small, and the effect of schools in predicting smoking rates was not statistically significant.
-Comparability at baseline: Not Indicated
-Attrition bias and missing data: A higher proportion of smokers were lost to follow up compared with non-smokers.

***Title:** Preventing Tobacco Use Among Young People in India: Project MYTRI
***Authors:** Perry et al. (2009)
***Programme name**: MYTRI (Mobilising Youth for Tobacco-Related Initiatives in India)
***Objective**: Project MYTRI was a multi-component school-based intervention aimed at preventing tobacco use (Cigarette use, bidis and chewing tobacco) among Indian adolescents in an urban area of India.
***Country:** India
***Site:** Schools in Delhi and Chennai, two urban cities in India
***Reason for site selection**: High tobacco use among urban adolescents

***Methodology:**
-Design: Randomised controlled trial in which schools were matched according to type of school, such as private vs governmental and coeducational vs girls only vs boys only
-Sample size:
-Originally from:
Schools: 32 schools (16 in Delhi, 16 in Chennai)

Individual participants: 12484 in 6th and 8th grade in 2004, 12075 in 7th and 9th grade in 2005 and 12752 in 8th and 10th grade in 2006.
-Participated:
Schools: 32 schools
Individual participants: 11,748 of original 12484 completed test in 2004 (94.1%).
-Retained
Schools: 29 schools (3 schools did allow participation of 10th graders in 2006).
Individual participants: 8, 369 (4360 in control/ 4009 in intervention) of original 11,748 completed test in both 2004 and 2005 (71%).
Also included further to make control 7698 and intervention 6365.
-Attrition
-Schools: 3 dropped out of original 32 (9%) by 2005
-Individual participants: 3379 dropped out of original 11,748 (28%) by 2004
-Power analysis
Not conducted
-Participants: Of 8, 369 participants in 2005
-Sex: 51.6% male and 48.4% female
-Average age and school grade: Mean age was 11 years for 6th graders, 12.1 years for 7th graders, 12.8 for 8th graders and 13.9 for 9th graders
-SE status: 56.4% were in government school and 43.6% in private school
-Procedure:
-Duration: Approx four months each over two school years (2004-2005, 2005-2006).
-Follow up: Data obtained midpoint of intervention (after one year) and on completion of the two year intervention.
-Intervention components: The intervention consisted of behavioural classroom curricula (consisting of 7 peer led classroom activities for 6th and 8th grade students in 2004-2005 and 6 additional activities for 7th and 9th grade students in 2005-2006), school posters (hung in schools each year, corresponding with classroom activity themes) a parental involvement component (6 postcards were sent home to parents during 2004-2005 school year) and peer led activism outside of the classroom (included competition between classrooms and schools. The components were designed to be generally relevant to the schools' settings, developmental stages and educational approaches. However, unique strategies were implemented as well, notably the use of an activity format in which elected peer leaders facilitated small groups).
-Control: Delayed intervention control
-Theoretical basis of intervention: Social Cognitive Theory, Action Theory, Conceptual theory, Social Influences Program
-Intervention delivered by: Teachers with trained peer leaders and field staff
-Intervention supervised by: Research staff
-Outcome measures
-Primary outcome: Tobacco use (including smoking status over last 30 days) and intentions
Primary outcome measures: The survey assessed self-reported current tobacco use via 3 questions to which students answered yes or no: (1) "During the last 30 days, did you chew tobacco in any form?" (2) "During the last 30 days, did you smoke 1 or more bidis?" and (3) "During the last 30 days, did you smoke 1 or more cigarettes?" Students who responded yes to 1 or more of these 3 questions were considered current users of any tobacco product.
-Secondary outcomes: Assessed 14 social, environmental, and intrapersonal factors associated with tobacco use, including knowledge, attitudes and self-efficacy.
-Secondary outcome measures: Survey
-Robustness of secondary outcome measures: The survey, which was administered in English, Hindi, or Tamil, was adapted from existing instruments and underwent rigorous pilot testing as well as reliability and validity testing.

-Process outcomes: participation rates, levels of fidelity.

***Analysis**
-Tests used: Used mixed-effects regression models for repeated measures data (i.e., growth curve analyses) to examine differences between the intervention and control groups over time. This method of analysis is appropriate for longitudinal investigations that seek to address questions about changes in behaviour over time and is robust and flexible, especially in regard to accommodating missing data and nested study designs. In the analyses, used a 3-level random coefficients model. Mean trajectories (i.e., changes in use or risk over time) for each student were modelled at level 1, mean trajectories for each school were modelled at level 2, and mean trajectories for each study group were modelled at level 3 (with appropriate variability modelled at each level). In

some cases, the 3-level model did not converge because there was no significant variability between schools; in these instances a 2-level model was used instead. Elected to use a linear model because there were only 3 time points. Time was centred at baseline and coded in years to reflect the timing of the surveys (i.e., 0, 1, 2). Assessed city (Delhi or Chennai), grade level (6th or 8th), type of school (government or private), and gender as possible effect modifiers of the intervention outcomes. Maximum likelihood methods (via the LISREL multilevel module) were used in estimating all of the models. Mixed-effects regression models were used to examine differences in the primary and secondary outcomes between the study conditions over time. These regression models are appropriate for studies like these given their unique design, as they account for the variability in the dependent variable between students and schools. In doing so, it protects the nominal type I error rate. The regression models use individual level data while appropriately accounting for the design effect inherent in the trial, namely that schools, not students, were randomised to study condition. The regression models were used to test for differences between the intervention and the control conditions, at the baseline survey. Then, they were used to test for differences between the intervention and control conditions, in the change from the baseline to the intermediate survey (i.e., analyses were done on ‘‘change scores’’ for each condition over time). All analyses were conducted with SAS 9.12 and its PROC MIXED (2006).

-**Adjustments for clustering**: Yes. Statistical analysis used which consisted of mixed-effects regression models, which accounted for the fact that schools and not individuals were used as the units of randomisation to intervention and control groups.

-Comparability at baseline: Yes – baseline levels of chewing tobacco use and cigarette smoking were equivalent among intervention and control group students. Analysis of covariance occurred to adjust for baseline differences

-Attrition bias and missing data: The attrition rate for the cohort was higher among both schools and students in the control condition compared with the intervention (31.5% versus 24.0%; $p< 0.01$) and for students who reported tobacco use at baseline compared with those who did not (44% versus 27%; $p< 0.01$), but there was no differential attrition between study conditions by tobacco use so attrition rates did not differ between study arms. Rates of missing data (at any time point) were higher among students who reported tobacco use ($p<.01$) but there were no between-group (intervention vs control) differences in missing data according to tobacco use (current vs ever) status ($p>.05$). Methods to account for missing outcome data (adjusted scale scores) were described. Missing data addressed in test (see tests used above).Subject survey missing data were removed from analysis.

***Title:** A Randomized Controlled Trial of the Middle and Junior High School D.A.R.E. and D.A.R.E. Plus Programs
***Authors:** Perry et al. (2003)
***Programme name**: D.A.R.E. only (Drug Abuse Resistance Education) and D.A.R.E. plus
***Objective**: To evaluate the effect of the middle and junior high school Drug Abuse Resistance Education (DARE) and DARE Plus programs on tobacco, marijuana, alcohol use and violence and victimization.
***Country:** USA
***Site:** Middle and Junior high schools in urban, suburban and rural areas of Minnesota, US with most from the Minneapolis St. Paul metropolitan area.
***Reason for site selection**: Not stated

***Methodology:**
-Design: Randomised controlled trial where schools were matched on socio-economic measures, drug (including tobacco) use and size
-Sample size:
-Originally from:
Individual participants: 6728 students in 7th grade in 1999-2000 and 7th graders in 2000-2001
-Participated:
Schools: 24 schools (8 each in both intervention groups and 8 in control)
Individual participants: 6237 participants in 7th grade were surveyed at baseline (2226= intervention 1/ 2221=intervention 2/ 1790 = control) in 1999-2000.
-Retained
Schools:24 schools
Individual participants: 5239 participants in 8th grade (who were originally 7th grade) (84% of original baseline sample of 6237) in 2000-2001.
Also included a further 2022 who had completed just one survey in either 1999-2000 or 2000-2001 so in total 7261 participants used for final evaluation.

-Attrition
-Schools: 0
-Individual participants: 16% (998 out of original 6237)
-Power analysis
Not statistical evidence of it conducted - School districts in Minnesota that had middle and junior high schools with a seventh grade population of at least 200 were targeted for sufficient statistical power.
-Participants:
-Sex: 51.6 % were male and 48.4% were female.
-Ethnicity: Of the 7261 participants, 67.3% were white, 7.5% were African American, 12.7% were Asian American, 3.6% were Hispanic, 4.0% were American Indian, and 4.9% were mixed or other racial/ ethnic groups.
School grade: 7^{th} and 8^{th} grade
-Procedure:
-Duration: Two school years (1999-2000 and 2000-2001)
-Follow up: Data collected midpoint of intervention (after 1 year) and at the end of the two year intervention
-Intervention components: The D.A.R.E. programme intervention consisted of a school-based curriculum involving skills in resisting influences to use drugs, focused on character building and citizenship skills. The D.A.R.E plus programme also incorporated a peer-led parental involvement classroom programme called "On the VERGE", which was a 4 session programme. The program was designed as a teen magazine, and the classroom activities focused on influences and skills related to peers, social groups, media, and role models. The narrator of the magazines was a "very cool" bear, named "Buddy DaBear." The 2 classroom activities each session were primarily led by elected and trained peer leaders. The last part of the magazine included "home team" activities for the students to complete with their parents related to these same themes.20 Students also participated in a theatre production in their classrooms and received 3 postcards through the mail that focused on the tobacco industry's targeting of youth.
As a follow-up to VERGE, 10 additional postcards were mailed to the parents about every 6 to 8 weeks, with short and relevant behavioural messages.
It also included youth-led extracurricular activities (which involved students in determining the types of extracurricular activities that would be created and in their planning and implementation. Eight community organisers were hired to create and facilitate the teams and extracurricular programs.).
Also community adult action teams (which were formed to address neighbourhood and school-wide issues related to drug use and violent behaviour. The same community leaders organised these action teams. The organisers were extensively trained in direct action community organising methods, as used in prior research)

-Control: delayed program control (8 schools served as "delayed program" control schools and had the opportunity to receive the DARE Plus programs in 2001-2002, after the final follow up)
-Theoretical basis of intervention: Not stated
-Intervention delivered by: The police officers who taught the middle and junior high school D.A.R.E. program had received training in the elementary school D.A.R.E. curriculum, had taught at least 2 semesters of D.A.R.E., and had received training in the middle and junior high school curriculum, according to the D.A.R.E. protocol. In addition, officers who were teaching D.A.R.E. in the D.A.R.E. Plus condition were provided an extra 2-hour training by the research team on interactive teaching methods.

-Intervention supervised by: research staff
-Outcome measures
-Primary outcome: Smoking status as measured by
-Primary outcome measures: Self-reported cigarette use over last month (10 response categories)
-Secondary outcomes: Tobacco use intentions
-Secondary outcome measures: Survey
-Robustness of secondary outcome measures: variables on survey tested for cronbach's alpha coefficient for reliability

***Analysis**
-Tests used: Growth curve analytic methods were used to assess changes over time by condition. This analytic method permits retention of subjects who do not have complete data. Differences between the D.A.R.E. only, D.A.R.E. Plus, and delayed program control conditions were tested using a 3-level, linear, random-coefficients model because it is recommended for group-randomised trials with 3 or more repeated observations on the same individuals or groups, because these models maintain an appropriate type I error rate. Instead of defining intervention effectiveness as the difference between group means at one point in time (via a mixed-model analysis of covariance, for example), a random coefficients model tests for differences in group slopes over an extended period. In doing so, it allows an assessment of the degree to which an intervention is able to positively

alter the normative growth or trajectory of behaviour over time. One of the strengths of this approach is its ability to appropriately model the structure of data arising from a cluster sampling scheme (such as students in schools) and missing data. It models the process of change not only for the population but also for individuals, and thus is useful when there are multiple levels, such as are found in school and community trials. More detailed explanations of random coefficients models (growth curve analyses and hierarchical linear models) can be found elsewhere. These models were used to evaluate the intervention's effect on relevant behavioural and psychosocial factors. Analyses were first conducted with all students and, because substantial interactions with sex were noted, were then conducted separately for boys and girls. Models were not adjusted for ethnicity, because baseline data showed equivalency between study conditions. All of the models were estimated using maximum likelihood procedures with the multilevel module in LISREL 8.50.
-**Adjustments for clustering**: Yes. Random coefficients model: One of the strengths of this approach is its ability to appropriately model the structure of data arising from a cluster sampling scheme (such as students in schools) and missing data.
-**Comparability at baseline:** Not indicated apart from ethnicity. Stated differences at baseline accounted for: models were not adjusted for ethnicity, because baseline data showed equivalency between study conditions.
-**Attrition bias and missing data:** Loss to follow up rates did not differ by study condition. There was no differential attrition between study conditions with regard to the main dependent variables in the analyses.
Missing Data: Growth curve analytic methods were used to assess changes over time by condition. This analytic method permits retention of subjects who do not have complete data.
Incomplete data accounted for: Growth curve analytic methods were used to assess changes over time by condition which permits retention of subjects who do not have complete data

***Title:** Effects of an Advocacy Intervention to Reduce Smoking Among Teenagers
***Authors:** Winkleby et al. (2004)
***Programme name**: Advocacy intervention
***Objective**: To test whether high school students' participation in advocacy activities related to the advertising, availability and use of tobacco in their communities would prevent or reduce their own tobacco use
***Country:** USA
***Site:** Ten continuation high schools in the San Francisco-San Jose area of northern California
***Reason for site selection**: because of high smoking rates in continuation schools

***Methodology:**
-Design: Randomised controlled trial using the toss of a coin
-Sample size:
-Originally from :
Schools: 10 continuation high schools which ranged in size from 97 to 300 students. All 11^{th} and 12^{th} grade students were eligible to participate.
-Participated:
Schools: 10 continuation high schools which ranged in size from 97 to 300 students. All 11^{th} and 12^{th} grade students were eligible to participate. 5 in control and 5 in intervention
Individual participants: 813 11^{th} and 12^{th} grade high school students (375 in intervention and 438 in control)
-Retained
Schools: 10 continuation high schools
Individual participants:798 out of original 813 (367 in intervention and 431 in control)
-Attrition
-Schools: 0
-Individual participants: 1.8% (15 dropped out of original 813)
-Power analysis
Not conducted (Commented that the initial class size of 25 allowed for attrition and provided a class size that lent itself well to intervention activities).
-Participants:
At baseline:
-Sex: 56.5% female in intervention and 43.7% female in control
-Ethnicity: Latino (43.5% in intervention and 40% in control), White (20.9% in intervention and 22.6% in control), Mixed (15.3% in intervention and 16% in control) , Asian or Pacific Islander (12.6% in intervention and 11.4% in control), African American (4% in intervention and 6.5% in control) and other ethnicities (3.7% in intervention and 2.7% in control)
-Mean age: 17 years for intervention and 17.1 years for control
-School age: 11^{th} and 12^{th} grade high school students (16-18 years)
-SE status: Father's educational level less than high school level (28.7% intervention and 30.9% in control)

-Procedure:
-Duration: four semesters over two school years
-Follow up: at completion of intervention and 6 month post completion of intervention
-Intervention components: The advocacy intervention was designed to modify proximal influences on cigarette smoking, build awareness of distal environmental influences on smoking and engage youth in devising strategies to modify environmental influences on cigarette smoking. The advocacy curriculum was provided in 3 phases. Phase 1 dispelled misconceptions about cigarette smoking and raised students' awareness about environmental influences on smoking in their schools and communities. Students learned about strategies used by tobacco companies to promote cigarette smoking among teenagers. Discussions were initiated about tobacco and its role in society to help teenagers clarify their beliefs and knowledge about tobacco use. Classroom and community- based sessions engaged students in activities to assess advertising, availability and access to tobacco in their community.
Phase 2 involved a daylong youth advocacy institute for students from all treatment schools. The youth advocacy institute agenda was designed to foster team building and to provide students with the opportunity to develop advocacy skills, practice persuasive communication, present the results of their community assessments of tobacco and choose an advocacy project that would be carried out during the remainder of the semester. Phase 3 assisted teenagers in developing, implementing and evaluating their community-advocacy projects. All of the community-advocacy activities involved researching a tobacco-related issue (e.g. conducting surveys and gathering and analysing data) developing educational materials (e.g. handouts about tobacco promotion to minors or descriptions of smoking laws for store owners) talking with people in power (e.g. school administrators, store owners, physicians or city council members) and evaluating progress. Students selected community-advocacy projects such as i) Form a task force of school administrators, teachers and students to enforce smoking bans on campus, 2) Reduce the amount of tobacco advertisements and promotions in stores that teenagers and children frequent, 3) Increase store compliance with laws and ordinances that limit tobacco advertisements on exterior windows, 4) Reduce cigarette sales to minors by local stores, 5) Eliminate magazines with cigarette advertising from medical and dental offices, 6) Convince city council members to decline campaign contributions from tobacco companies
-Control: Receiving an existing program about drug and alcohol abuse prevention.
-Theoretical basis of intervention: Social Learning and Empowerment Theory
-Intervention delivered by: Staff of the Stanford prevention research centre, California
-Intervention supervised by: Staff of the Stanford prevention research centre, California
-Outcome measures
-Primary outcome: Smoking status
-Primary outcome measures: Co readings and self-reported via standardised question on survey that asked 'how much do you smoke now?' Students were classified as non-smokers, light/experimental smokers or regular smokers based on responses:
-Secondary outcomes: 3 constructs related to social cognitive theory; perceived incentive value, outcome expectancies and self-efficacy.
-Secondary outcome measures: Survey
-Robustness of secondary outcome measures: Survey: internal consistency for each construct based on baseline values (cronbach alpha).3 constructs: perceived incentive value: cronbach alpha score 0.93, perceived self-efficacy: cronbach alpha score 0.89, outcome expectancies: cronbach alpha score 0.87).
-Process outcomes: Level of involvement in community advocacy: the number of tobacco-related advocacy activities in which teenagers were involved during the preceding 5 months. Eight types of activities plus 1 open-ended question for additional activities were listed that pertained to the types of activities that we intended the intervention students to be involved with (e.g. conducting background research, making presentations to school administrators or community store owners, surveying school or community members about a tobacco issue, or working with the media, police or schools on a tobacco-related issue)
-Process outcome measures: Survey questions - community advocacy: cronbach alpha score 0.83.

***Analysis**
-Tests used: Used the school as opposed to individual students as the unit of analysis and thus avoided potential interclass-correlation bias where students could influence each other's cigarette smoking behaviour.
Used two-tailed 2 sample t tests because the test is known to be robust against violations of normality and makes no assumptions about the covariance structure of the data.
-Adjustments for clustering: Yes. The analysis process followed the experimental design that was based on randomisation at the high school level. This design allowed to use the high school rather than individual students as the unit of analysis and thus avoided potential interclass-correlation bias where students could influence each other's cigarette smoking behaviour.
-Comparability at baseline: Not comparable - There were slight differences in baseline smoking and/or sociodemographic characteristics between the treatment and control high schools.

***Title: The European Smoking Prevention Framework Approach (ESFA): Effects After 24 and 30 Months**
***Authors:** De Vries et al (2005)
***Programme name**: ESFA (European Smoking Prevention Framework Approach)
***Objective**: The European Smoking Prevention Framework Approach (ESFA) study in six countries (Portugal, Finland, Spain, Netherlands, Denmark, UK) tested the effects of a comprehensive smoking prevention approach after 12, 24 and 30 months.
***Country:** Portugal, Finland, Spain, Netherlands, Denmark, UK
***Site:** Schools in the cities of Madrid and Barcelona in Spain, two rural regions of Denmark, city of Helsinki in Finland, five rural and urban regional health authorities in The Netherlands and two health authority regions in the UK
***Reason for site selection**: Not stated

***Methodology:**
-Design: Quasi experimental (randomised controlled took place in four countries but not in Spain and The Netherlands.
-Sample size:
-Participated:
Schools: 235 schools (control 124/ intervention 111)
In Finland 27 schools (13 intervention and 14 control)
In Denmark 60 schools (30 intervention, 30 control)
In the UK 43 schools (22 intervention, 21 control)
In Portugal, 25 schools (14 intervention, 11 control)
In the Netherlands 33 schools (16 intervention, 17 control)
In Spain, 47 schools (16 intervention, 31 control)
Individual participants: 23,531
-Retained
Schools: 233 schools
Individual participants:9282 (at T4)
-Attrition
-Schools: 1% (2 schools out of 235)
-Individual participants: 61 % (9282 out of original 23531 responded so lost 14249)
-Power analysis
Conducted:
For each country, power calculations were run with the software programme Power (Lawrence Erlbaum Associates) in order to estimate the number of pupils to be included in each national sample. Power analysis calculations were based on the smoking incidence rates of adolescents at the age of 15 years, the age of most pupils at the time of the third post-test. Based on earlier experiences, a dropout rate of 30% was hypothesized for all countries except for Finland, where a 20% dropout rate was expected. The participating countries could be divided into two groups: countries with a relatively low last 4-weeks smoking incidence at the age of 15 years (29% or less: Denmark, Finland and Portugal) and countries with a higher incidence (between 34.5 and 41%: The Netherlands, Spain and the UK). Applying conservative parameters (significance level of 0.001 and power of 0.95) and hypothesizing differences between the probabilities of success (p) in both conditions of 10% (e.g. p = 0.29 in the control condition and p = 0.19 in the experimental condition), the power calculations resulted in recommended sample sizes of at least 2x 1200 pupils for the countries with a relatively low smoking incidence and at least 2 x 1500 pupils for countries with a higher incidence (including expected dropout).
-Participants:
At T1 baseline
-Average age: 13.3 years
At T2 (15,422 participants)
-Sex: 49.8% boys and 50.2% girls
-Ethnicity: Non native born 13%
-SE status: Father works 5 days a week = 74.1%/Mother works 5 days a week = 47.7%
Procedure:
-Duration: 30 months
-Follow up: Data collected one year into the intervention, two years into the intervention and at the end of the intervention.
-Intervention components: The programme targeted four levels, i.e. adolescents in school, school policies, parents and the community
1 & 2) Adolescents in school and school policies level: Denmark had 12 lessons, Finland 14, Netherlands 9, Spain 18, Portugal 14 and the UK 9; All addressed decision making; All apart from the UK addressed refusal skills training, social pressure/influence and health consequences; All apart from the UK and Denmark addressed public

commitment to non-smoking; All apart from Denmark, Netherlands and Spain addressed tobacco and environment.
2) School level: Teacher manual provided for all; All apart from Denmark had a school contact person and a smoke-free competition; All apart from Spain had a school policy manual disseminated; All apart from the UK used posters; All apart from Finland had teacher smoking cessation materials offered; Teacher training provided for all apart from Denmark and Netherlands.
3) Parental level; All countries informed the parents about the project and its goals; All apart from Finland had a parent brochure about how to talk about smoking with their children; All apart from the UK had a parent brochure about smoking cessation and offered parent meetings; All apart from Finland and Netherlands had cessation courses like, Quit and Win offered.
4) Out of school level: All disseminated posters in the community; Finland and Portugal had publication in local media; Finland and Netherlands had community actions for children such as non-smoking activities like youth camps and sports clubs and behavioural journalism.
-Control: Standard care
-Theoretical basis of intervention: The Attitude Social Influences Self-Efficacy (ASE) model which originated from the Theory of Reasoned Action but also incorporated elements from Social Cognitive Theory, The Trans-theoretical Model and Precaution Adoption Model.
-Intervention delivered by: Trained teacher-led
-Intervention supervised by: Research staff
-Outcome measures
-Primary outcome: Smoking status
-Primary outcome measures: Self-reported smoking status on survey asking ever-smoking and weekly smoking. These items were assessed by a combination of five questions that were cross-validated (De Vries et al 2003). Adolescents were categorised as never-smokers (never smoked a puff), non-smoking deciders (experimented with smokers, but had quit experimenting), experimental smokers (experimenting with smoking, but not smoking weekly), weekly smokers (smoking at least once a week), daily smokers (smoking at least once a day) or as quitters (tried smoking at least weekly, but not smoking anymore). The validity of adolescent self-reported smoking is high in concordance with biological indicators when measurement assures anonymity (Dolcini et al 1996). Hence, we optimised measurement conditions by assuring respondents of the confidentiality of their responses (Murray et al, 1987; Hansen 1992; Dolcini et al 1996).
-Secondary outcomes: intentions, attitudes, self-efficacy
-Secondary outcome measures: ESFA questionnaire
-Robustness of secondary outcome measures: The questionnaire was based on a review of the literature, 15 years of work on adolescent smoking behaviour and revised according to pilot studies conducted by the NPMs in each country. Secondary outcomes in the study were the pros (six items on a seven-point scale; alpha=0.65) and cons of smoking (five items on a seven-point scale; alpha=0.68), social self-efficacy (three items about refraining from smoking in social situations; alpha=0.94), situational self-efficacy (three items about refraining from smoking in various situations, alpha= 0.93), stress self efficacy (three items measuring self-efficacy when stressed; alpha=0.96), and intention to smoke in the future (measured by one item). Other items included age, gender, pocket money, religious background, ethnicity, alcohol consumption, soft and hard drug use, family status (disrupted or not), parental occupation, social norms of parents, siblings and peers, social pressure to smoke from parents, siblings and peers, social modelling of smoking from parents, siblings and peers, parental reactions towards smoking, school achievement, school policy towards smoking, and if smoking was discussed during the previous year in school and at home.

***Analysis**
-Tests used: Dropout from the study was assessed using logistic regression. Where significant interactions were found between the predictors and country, separate analyses were run per country. The t tests assessed the extent of exposure to the lessons using items from the process evaluation. Differences between the experimental and control groups on attitudes, self efficacy expectations and intention were analysed using covariance analyses. Baseline smoking behaviour and the demographic variables were includes as covariates. Adolescents who responded to T1 and T3 or T1 and T4 measurements, had answered at least 90% of the questionnaires, and did not have the missing values in the outcome variable were included in the behavioural effect analysis. Due to the fact that subjects were nested within classes, schools, quarters, municipalities, regions as well as countries, logistic regression using multilevel procedures were used to analyse differences in ever and weekly smoking prevalence rates. Non-significant predictors and interactions were deleted using a backward deletion procedure (alpha=0.05) with the restriction that predictors were not removed from the model if they were involved as interaction terms. Demographic variables and the adolescent attitudinal, self-efficacy and intention scores at T1 were included as covariates. Covariates were included to correct for potential baseline differences and to increase power. Previous research has shown the (potential) relationship of these covariates with smoking and the treatment condition. A similar procedure was followed for the analyses of the T3 and T4 data.
-Adjustments for clustering: Yes. Due to the fact that subjects were nested within classes, schools, quarters,

municipalities, regions as well as countries, logistic regression using multilevel procedures were used to analyse differences in ever and weekly smoking prevalence rates. **-Comparability at baseline:** Covariates were included to correct for potential baseline differences and to increase power. **Attrition bias and missing data:** dropout from the study was assessed using logistic regression. At T4 the response rates were lower among adolescents who were male, older, non-religious, with a mother working more than 5 days per week, had more pocket money and who had higher school achievements. Dropout rates at T4 were slightly higher in the experimental condition (52.3%) than in the control condition (50.2%) but did not differ significantly. Denmark and Portugal reported a reverse pattern of response rates between the experimental and control groups (45.9 versus 52.6% for Denmark and 41.7 versus 39.1% for Portugal). In Finland two control group school decided not to continue to participate in the program due to time constraints, resulting in a dropout rate of 45.7% in the control condition versus 27.2% in the experimental condition.	
Results for never smokers becoming ever smokers **Only T3 and T4 data only available**	**T3 DATA (AFTER 24 MONTHS)** -Overall not significant: 44.1 of the T1 never smokers in the control group became ever smokers in T3 compared to 44.8 of the experimental group (OR=0.99/ CI: (0.90-1.09)/ p<0.86) - In specific countries not significant in Finland, Spain, UK -Significant effect in Portugal, 41.5% of the T1 never smokers in the control group became ever smokers in T3 compared to 33.8% of the experimental group (OR=0.73/ CI: 0.57-0.94)/ p<0.02) -Borderline counter effect In Denmark, 43.6% of the T1 never smokers in the control group became ever smokers in T3 compared to 49.3% of the experimental group (OR=1.41/ CI: (0.96-2.06)/p<0.08) Borderline counter-effect in The Netherlands, 36.6% of the T1 never smokers in the control group became ever smokers in T3 compared to 41.7% of the experimental group (OR=1.21/ CI: (0.98-1.49)/ p<0.07) **T4 DATA (AFTER 30 MONTHS)** Overall not significant, 52.7% of the T1 never smokers in the control group became ever smokers at T4 compared to 51.7% of the experimental group (OR=0.93/ CI: (0.84-1.03)/p< 0.18) -In specific countries not significant in Denmark, Finland, The Netherlands, UK. -Significant effect in Portugal, 53.8% of the T1 never smokers in the control group became ever smokers at T4 compared to 41.8% of the experimental group (OR= 0.62/ CI: (0.48-0.80)/ p<0.01) -Significant effect in Spain, 68.9% of the T1 never smokers in the control group became ever smokers at T4 compared to 64.5% of the experimental group (OR= 0.75/ CI: (0.55-1.00)/ p<0.05)