

Acknowledgements

This pilot campaign has been conducted by Smoke-Free Merseyside and funded by the Department of Health. Thanks are extended to the wider Alliance and partners for their guidance and support, in particular:

The Merseyside PCT Tobacco Leads:

Cathy Warlow, South Sefton, Southport and Formby

Sandra Davies, Liverpool

Sue Drew, Wirral

Liz Gaulton, Knowsley

Brenda Fullard

Public Health Department Government Office for the North West

Andrew Cornes

Andrew Dineley

Liverpool Health Promotion Service Design Studio

Christine Owens

Roy Castle Lung Cancer Foundation

Research commissioned by Smoke-Free Merseyside:

Mark Wilson

Knowsley Clinical Governance

Post training evaluation

Richard Glendinning

NOP (National Opinion Poll)

Post campaign media evaluation

We would also like to thank those who participated in the pilot:

The Sure Start Programmes

Bootle/Litherland, Birkenhead, Knowsley, West Everton/Breckfield

The management team, Wirral Services for Child Health (WiSCH)

Alistaire Bardsley

Pauline Riding

Members of Smoke Free Merseyside who have since moved on:

Ian Canning

Katie Dee

Leonie Richards

This report was written by:

Suzanne Aspinwall

Gina Mc Daid

Tina Williams

Contents

Executive Summary	4
Background	7
Campaign Aim and Objectives	9
Management Structures	10
Objectives One and Two: Methodology	11
Evaluation Findings:	
Objective One	12
Objective Two	20
Finance	24
Difficulties and Restraining Factors	24
Recommendations	25
References	26
Appendices:	
Appendix 1 - Campaign materials	27
Appendix 2 - Radio advert script	28
Appendix 3 - NOP questionnaire	28
Appendix 4 - Training attendance	30
Appendix 5 - Training course questionnaire	31
Appendix 6 - Training feedback summary	32
Appendix 7 - Financial breakdown	34

Executive Summary

Background and Objectives

During the summer of 2003, a pilot project was conducted by Smoke-Free Merseyside to highlight the dangers of passive smoking to children particularly those most likely to be at home, i.e. the pre-school age group.

The campaign had two main objectives:

- 1 To increase public knowledge and awareness of the dangers of passive smoking via an advertising campaign.
- 2 To change parental behaviour and therefore reduce children's exposure to passive smoke within the home environment through the intervention of health professionals.

The promotional campaign, designed to meet objective one, included a range of activities such as Adshel bus shelter advertising in the target areas (the Sure Start locations of Bootle/Litherland, West Everton/Breckfield and Birkenhead North). There was also leaflet distribution directly to the homes of families registered with Sure Start and leaflets and posters were placed in public locations such as GP surgeries. A radio advertisement was extensively aired on Radio City.

To meet objective two a half-day training programme was developed centred around a five-point action plan:

- 1 Assessing children's exposure to passive smoking.
- 2 Raising the issue with parents or carers.
- 3 Assessing readiness to change.
- 4 Taking action – according to readiness to change.
- 5 Follow-up.

Health and other professionals from within the target areas were invited to attend – 93 people participated in the training.

Evaluation

Objective One

It was considered important to get some independent assessment of the impact of the campaign, National Opinion Poll (NOP) Social and Political were commissioned to conduct a post-campaign survey with a sample of parents of pre-school children in the Sure Start areas. The objective of the survey was to check for awareness of the campaign and the media used as well as to examine the understanding of the key messages and make a broad assessment of the impact

Objective Two

Evaluation of the training took place in two stages:

- An immediate reaction evaluation completed at the close of the session.
- A follow-up questionnaire sent out 8 to 12 weeks later, to assess the impact on practice.

Summary of the Main Findings

Objective One

Smoking prevalence in the sample was strikingly high, 57%, twice the national adult average. Smokers lived in two out of three households.

In a third of smoking households, a parent smoked in front of pre-school age children. This equates to about one-in-five of the overall sample of households.

Nearly 90% of respondents correctly defined passive smoking (without prompting). There was widespread agreement (75% agreeing very strongly) that children should avoid being in smoky places but fewer people (47%) agreed strongly that they actually avoid taking their children into smoky places.

While four-fifths of the sample strongly agreed that passive smoking is a serious health risk for children, a quarter of the sample indicated that passive smoking didn't really worry them!

Some 40% of smokers agreed that they only smoked outside the home indicating that there is potential for further parental behaviour change.

There was a high level of recognition of the link between passive smoking and a whole range of respiratory conditions (e.g. asthma and chest infections) but fewer people saw an association with more serious illnesses such as heart disease and cancer.

Nine out of ten respondents had seen some recent advertising or publicity about passive smoking.

One person in five could recall the Radio City advert, half of the sample claimed to have previously heard the campaign slogan. The Blackboard poster was the most commonly recalled image.

In overall terms, levels of recall of the campaign were very respectable e.g. 45% of smokers have seen/heard something. 84% of respondents agreed with the idea that the adverts had made them think more deeply about the risks of passive smoking indicating that the messages have potential for influence.

Even with the small samples used in this study, there is evidence of greater resistance to the health messages in Birkenhead than in the other two Sure Start areas.

While many people understood the dangers of passive smoking, there is evidence in the research that the risks are played-down and behaviour often does not reflect knowledge.

Objective Two

The audit findings indicate that health professionals increase their knowledge, skills and confidence by undertaking the passive smoking intervention training and that it has had a direct and sustained impact on their day-to-day patient care.

Discussion and Recommendations

Objective One

The high level of smoking prevalence identified justifies the targeting of this particular population. The simple fact that most pre-school parents in these areas are smokers demonstrates the need for more activity to facilitate change in parental behaviour to reduce children's exposure to passive smoking. The campaign materials seem appropriate and have the potential for considerable impact.

Experience elsewhere suggests that if smokers have to delay lighting up a cigarette they are converting smoking from a subconscious reflex decision to a conscious decision. They have time to think about why they are smoking and this helps in cutting levels of consumption or stopping altogether.

More research is needed to explore the 'contradictions' in the data (e.g. the gap between knowledge and behaviour) and other issues such as the modest linkage between passive smoking and serious health conditions.

Recommendation One

There should be follow up research that is qualitative in nature, making use of either individual interviews or group discussions to further explore the contradictions in the data.

Recommendation Two

The recent adverts should be tested again in any qualitative work to assess which images respondents found most powerful.

Recommendation Three

Any future repeat of the campaign should involve 'pre' as well as 'post' interviewing to demonstrate the impact more clearly than was possible on this occasion.

Objective Two

The training offered those working with the target audience a realistic alternative to use with parents or carers when giving up smoking was not a viable option, and as such the scope for use in practice is enormous.

Providing this short training session increased the skills, knowledge and confidence of those working with the target group and significantly increased the likelihood of them intervening with parents and carers both in the short and long term.

Recommendation Four

The training should be rolled out to appropriate staff members across Merseyside and a train the trainer pack should be developed to enable others to deliver the intervention.

Recommendation Five

Where possible this half-day module should be built into mandatory training and education courses for key professional and voluntary personnel.

Recommendation Six

More research should be implemented to assess the impact of brief interventions around passive smoking on parental smoking behaviour.

Further Recommendations:

"Overall this was clearly a successful campaign. It is important that the momentum is not lost. Gains need to be built on to remain in the public's mind. It is therefore important that further funding is secured to develop the campaign and roll it out over a larger area. It is felt the DOH could look at the potential of rolling it out nationally as part of NHS smoking communications campaign" ¹³

Recommendation Seven

Partners must be consulted prior to campaign planning to ensure that their needs are met and a sense of ownership, co-operation and commitment is achieved.

Recommendation Eight

Funding needs to be identified to increase the scope of the campaign by rolling it out over a larger area and to conduct further research as identified.

Recommendation Nine

The campaign should be considered as a model for regional and/ or national action.

Recommendation Ten

The campaign should be entered for appropriate Healthcare Communicators Award.

Recommendation Eleven

The campaign outcomes should be disseminated to other alliances.

Recommendation Twelve

Communication between those working at ground level and within the Tobacco Policy Unit at the Department of Health must be improved.

Smoke-Free Merseyside Alliance Passive Smoking Health Promotion Campaign

Background

Tobacco smoke contains a noxious mix of more than 4,000 toxic chemicals, released into the air as particles or gases, 60 of which are known carcinogens, which cause mutations in living cells¹. Tobacco smoke poses a significant threat not only to the health of smokers but also to those who involuntarily inhale the tobacco smoke of others; children are particularly at risk.

Research conducted over the last 25 years has consistently demonstrated the detrimental health effects of passive smoking. In 1998 the UK's Scientific Committee on Tobacco and Health concluded that passive smoking increases the non-smokers risk of developing lung cancer by 20-30%², heart disease by 30% and stroke risk by 82%³ In other words 'Passive Smoking Kills'.

Short-term inhalation of passive smoking causes the non-smoker to suffer headaches, dizziness, nausea, sore throat and eye irritation. Those with asthma may experience a significant decline in lung function and 30 minutes exposure is enough to reduce coronary blood flow in a fit healthy adult⁴. Ironically many non-smokers suffer in silence either through ignorance or fear of causing offence by asking a smoker to stop.

Risk to young children

Approximately 42% of British children are exposed to tobacco smoke within the home. Children from lower income families are more likely to be exposed (54%) in comparison to those from professional households (18%)^{5/6}. »

» Infants of parents who smoke are more likely to be admitted to hospital suffering from bronchitis and pneumonia in the first year of life and more than 17,000 children under the age of five are admitted to hospital every year as a result of exposure to passive smoking⁷. In 1997 the UK spent £167m on medical care for children affected by passive smoking⁸.

Children are more susceptible to the effects of passive smoking, because they breathe more rapidly and consequently absorb more of the toxic chemicals. Passive smoking increases the child's risk of ear infection, asthma, bronchitis, meningitis, cancers and leukaemia. It also has adverse impact on learning and development. Parental smoking is a risk factor for sudden infant death syndrome (cot death). Children are unable to protect themselves from these risks and must rely on adults to act on their behalf.

"Passive smoking in the home is an important source of exposure because children spend most of their time at home and indoors. Unlike adults, who can choose whether or not to be in a smoky environment, children have little choice. They are far less likely to be able to leave a smoke-filled room if they want to. Babies can't ask; some children may not feel confident about raising the subject; and others may not be allowed to leave even if they ask."⁹

Public Awareness

Exposure to tobacco smoke among children in England has approximately halved since the late 1980s, partly due to the reduction in the prevalence in adults smoking and smoking restrictions in many enclosed public spaces e.g. hospitals, schools, public transport, cinemas and some shopping centres.¹⁰

In Oxfordshire a survey indicated that approximately 64% of parents with children aged between 3-5 years, smoked in front of their children (Cited in Lund et al¹¹). A poll conducted on behalf of 'Smoke Free London', tobacco alliance, revealed very low awareness of the health risks of passive smoking to children. Less than 26% of parents interviewed identified asthma as a likely impact. Two of the most common ailments linked to passive smoking – cot death and glue ear – were identified by only 3% and 1% of parents respectively (Cited in ASH9).

It has become evident that a large majority of smokers are unaware of the health hazards of smoking in general¹². Therefore it is conclusive that parents and carers need to be educated about the potential health risks of passive smoking.

Reducing Children's Exposure to Passive Smoking through Education

Internationally and nationally, a number of interventions have proven to be successful in reducing children's exposure to passive smoking in the home.

For instance media campaigns are great for creating a high profile. In the UK, NEAT, North East Alliance Against Tobacco, conducted a campaign of this nature to raise awareness amongst parents and carers of the impact of passive smoking on children. The post evaluation revealed that almost 25% of smokers indicated that they would protect their children from passive smoking, two thirds of carers said they would avoid taking the children to smoky environments and 12% of smokers reported that were more likely to give up smoking¹³.

Evidence also indicates that the message is most credible if delivered through a number of intermediates, especially by a GP. This is particularly so for families of low economic status who are exposed to passive smoking.

Further research insists the best way to reach this group is to convey the message face to face, via health professionals¹⁴, particularly to women as they are more susceptible to health messages if it concerns their children, provided it is not delivered in such a way that they are made to feel guilty¹⁵.

With this in mind, a five-step procedure was developed in the Netherlands for health professionals to discuss with parents about preventing passive smoking. The prevalence of smoking in the presence of infants aged 0-10 months was compared before and after the implementation of the education programme. The findings indicate a reduction in passive smoking from 41% in 1996 to 18% in 1999¹⁶.

In Norway¹⁴ and California¹⁷ a similar approach was also used to reduce the number of children exposed to smoke by making health professionals allies; motivating them to communicate by providing them with a range of smoking prevention child-friendly resources.

Rationale

Following a review of the evidence Smoke Free Merseyside elected to use the Tobacco Alliance funding of £20,000 for the year 2002/3 to reproduce the best aspects of the latter work described to create a local pilot campaign

Campaign Aim and Objectives

The aim of the campaign was to protect children from the dangers of passive smoking and this was underpinned by two objectives:

Objective One

- To increase public knowledge and awareness of the dangers of passive smoking via an advertising campaign.

Objective Two

- To change parental behaviour and therefore reduce children's exposure to passive smoke within the home environment through the intervention of health professionals.

Target Audience

Merseyside has a population of 1.3 million people, covered by the Tobacco Alliance, Smoke Free Merseyside. Given the size of the available budget it was not practical to attempt blanket coverage of this area. Targeting specific populations within the region, as a pilot study, allowed the development of a more focused marketing strategy as well as the design of a more rigorous evaluation process. Smoke Free Merseyside is committed to the goal of reducing health inequalities and due to high smoking prevalence in lower socio-economic groups, four Sure Start areas were selected; one each in Liverpool, Sefton, Knowsley and Wirral.

Additional work was carried out within Wirral Services for Child Health (WiSCH), who had previously been approached to take part in a similar campaign. For practical purposes it was decided to incorporate this with the Smoke Free Merseyside campaign.

The Message

It can be argued that smokers should be encouraged to give up smoking therefore automatically reducing exposure to passive smoking. However the addictive nature of nicotine means that for many the desire to stop is great, stated by 70% of the smoking population, however the ability to do so in the long term remains low, particularly amongst lower socio-economic groups¹⁸.

This is particularly the case for pregnant women who stop smoking during pregnancy, but after the delivery, frequently relapse into their previous smoking habits, partly caused by the fact that women do not realise that passive smoking can be dangerous for the child¹⁹. When coupled with the rise in young females taking up smoking²⁰, it is highly likely that children will continue to be exposed to tobacco smoke in the home for the foreseeable future. Therefore the need to inform parents of the dangers of passive smoking and how they can take action to reduce the risks to their children is imperative.

With this in mind the campaign and its messages were designed to reflect good practice i.e. simple, clear, non-victim blaming. It centred on protecting children from passive smoking rather than telling people to quit smoking or marketing smoking cessation services. The campaign maintained a continuity of branding ensuring that the message was consistent and transferable over all mediums of advertising.

Management Structure

Smoke-Free Merseyside Alliance, with the support of their partners, managed the initiative.

Partners included:

Sure Start Staff from each of the recruited areas:

- Bootle/Litherland
- West Everton/Breckfield
- North Birkenhead
- Knowsley

The following NHS Primary Care Trusts:

- Bebington and West Wirral
- Birkenhead and Wallasey
- Central, North and South Liverpool
- South Sefton
- St Helens and Knowsley

Health Links, Wirral Specialist Health Promotion Service

Liverpool Health Promotion Service

South Sefton Health Improvement Support Service

St Helens and Knowsley Health Promotion Service

Public Health Department Government Office for the North West

Roy Castle Lung Cancer Foundation

Wirral Services for Child Health (WiSCH)

Objective One

To raise the public awareness of the real dangers of passive smoking with a specific focus on passive smoking in the home and its harmful affects on children, via an extensive advertising campaign in the form of radio, bus shelter, newspapers and poster mediums over a 1 month period.

Marketing Mediums

The media aspect of the campaign took place during June 2003, it was felt that selecting a summer month facilitated parental behaviour change and increased the likelihood of smoking taking place outside the home.

The following marketing mediums were selected to expose the maximum number of people living within the Sure Start areas to the campaign message.

1 Bus Shelter Hoardings

Bus shelter advertising was selected for the display of posters because they are static, which fitted with the need to maximise impact within tight geographical locations and specific target populations. They also provided a means of targeting Sure Start families, whose socio-economic status indicates that they would be most likely to access public transport.

2 Local Newspapers

A number of press releases were circulated and published in both local and regional newspapers.

3 Poster/Leaflet

Using the same message and branding, posters and leaflets were displayed across the target areas within a range of settings i.e. pharmacies, health centres, nurseries, dentists, libraries, clinics, community centres, schools etc. Leaflet were distribution directly to the homes of all families registered with Sure Start (see appendix 1).

4 Radio Advertising

A radio advertising campaign was devised and aired on Radio City (see appendix 2), a popular local station that offers access to the whole population of Merseyside. The 30 second advertisement was aired 10 times per day, between the hours of 9am and 5pm, during the last 2-weeks of June. This schedule was chosen because information provided by the station suggested that it provided the greatest access to the target audience.

Objective Two

Objective two was to change parental behaviour and therefore reduce children's exposure to passive smoking in the home through the intervention of health professionals.

Training of Professionals

A number of studies support the provision of brief interventions by those who work with children and their parents or carers as an effective mechanism in reducing children's exposure to passive smoking by encouraging sustained parental behaviour change (see background information).

Evidence evolving from the work carried out in the Netherlands and Norway clearly demonstrates that training and the support of key professionals would be pivotal to the success of the initiative. Sure Start has established close links with both NHS and other statutory and voluntary sector partners within the target communities. Additionally, they are committed through their own business objectives to reducing respiratory illnesses within their localities. It was thus proposed that the Smoke Free Merseyside Network work closely with its Sure Start partners in securing professional commitment to participation in the training. Additional work was undertaken to enable staff employed with WiSCH to undertake the training. »

» To facilitate this aspect of the campaign Smoke-Free Merseyside developed a half-day training programme adapted from the Netherlands Study Five-Step Plan, which to avoid confusion was renamed the Five-Point Plan to address the following:

- 1 Assessing children’s exposure to passive smoking.**
- 2 Raising the issue with parents or carer’s.**
- 3 Assessing readiness to change.**
- 4 Taking action – according to readiness to change.**
- 5 Follow-up.**

The training was based on Prochaska and DiClemente’s²¹ Cycle of Change and motivational interviewing techniques, which have been shown to be effective in encouraging and supporting sustained behaviour change, particularly related to smoking cessation; this was adapted to the issue of children’s exposure to passive smoking.

The aims of the training were specified as:

- 1 To introduce the participants to the Smoke Free Merseyside Passive Smoking Campaign.**
- 2 To provide participants with a simple five-point plan to use when undertaking brief interventions aimed at reducing passive smoking in the home.**

These aims were underpinned by specific learning outcomes.

A flyer, using the campaign logo, was circulated to health and other professionals within the four Sure Start areas and staff based within WiSCH. The training was offered on a range of dates during May 03 to enable participants to support the media aspects of the campaign planned for June. Appropriately qualified and experienced members of the Smoke-Free Merseyside Team acted as trainers.

Following the introduction and icebreaker the training was divided into five sub-sessions (Appendix 5), which enabled a staged approach to the introduction of the Five-Point-Plan. The experiential teaching methods used within the training allowed participants to marry together existing skills, experience and knowledge, with new information. Session 6 used small group work and case studies to draw the strands of the training together and to enable participants to put the Five-Point-Plan into practice in a safe environment.

Evaluation Findings

Objective One

It was considered important to get some independent assessment of the impact of the media aspect of the campaign. NOP (National Opinion Poll) Social and Political were commissioned to conduct a post-campaign survey with a sample of parents of pre-school children in three of the Sure Start areas (a number of issues prevented St Helens and Knowsley participating in this aspect of the evaluation).

The use of radio advertising meant that there was little value in using other Sure Start locations as ‘control’ areas. The objective of the survey was to check for awareness of the campaign and the media used as well as to examine the understanding of the key messages and make a broad assessment of the impact.

Research Methodology

Data Collection

Bearing in mind the relatively small areas being researched, the disadvantaged communities covered by Sure Start and the need to use visual stimuli, the only credible way to collect the survey data was by means of face-to-face interviewing within the three locations.

Sampling

Three Sure Start areas were mapped and then each divided into twelve approximately equal-sized sections. Interviewers were instructed to contact the parents of children aged 0-4. A total of 324 interviews were conducted with parents/guardians of pre-school children including 104 in Birkenhead North, 111 in West Everton/Breckfield and 109 in Bootle/Litherland.

The Questionnaire

The questionnaire was prepared from discussions between NOP and Smoke-free Merseyside and went through a number of alterations before being finalised by all parties to the research. (see Appendix 3)

Survey Administration and Analysis

All fieldwork on the survey was conducted by fully trained members of the NOP fieldforce, working to the criteria of the Interviewer Quality Control Scheme. Interviewing took place between 14 and 27 July 2003. Completed questionnaires from the survey were returned to NOP's data centre where they were checked-in and given a brief sight-edit before being booked-in. Valid questionnaires were punched onto a computer system using a key-to-disk method with 10% verification of all punching.

Once on the system, data were subjected to a detailed computer edit to isolate any errors, omissions or inconsistencies. Where necessary, reference was made back to the original questionnaires. From the clean data, tabulations were run to a specification agreed with Smoke-free Merseyside, these tables are included in the report volume.

The Main Findings

Sample Profile

The sample for the survey consisted of 69 men (21%) and 255 women (79%). There were 91 (38%) were aged under-25, while 159 (49%) were between 25 and 34 years and 74 (23%) were aged 35 or over. Some 91 respondents (28%) were in paid work while 233 people (72%) were not themselves working at the time of the interview.

Smoking Prevalence and Smoking Behaviour

The interview began with a check to see what proportion of the sample lived in households where someone smoked. Prevalence figures were strikingly high with 57% of respondents across the three areas saying that they smoked themselves, while 22% said that someone else in their home was (also) a smoker - overall, only just over a third of homes were smoke-free.

National research has showed that 27% of the adult population of Britain are smokers (General Household Survey 2001). The GHS data is not broken down by the very specific population group covered in this survey but the relevant figures from 2001 showed that 35% of British people aged 20-34 were smokers as were about 33% of those in manual-occupations.

From these figures, we can estimate that close to 40% of 20-34 year olds in blue collar households were smokers in 2001. It is clear from these figures that the relative levels of smoking prevalence are high, in these three Sure Start areas. Prevalence was high in all age groups in the sample but declined somewhat with age (62% of the under-25s were smokers compared with 50% of the over-35s).

Table 1**Do you or does anyone else who lives in your home smoke?**

	Yes (respondent)	Yes (someone else)	No (no one)
Total	57%	22%	36%
Birkenhead North	67%	18%	30%
Bootle/Litherland	51%	19%	38%
West Everton/Breckfield	52%	28%	40%

Base: all = 324

Table 2**And do you/they smoke in the presence of children when they are at home?**

	Yes	No	Don't Know
Total	33%	66%	1%
Birkenhead North	40%	60%	0%
Bootle/Litherland	22%	77%	1%
West Everton/Breckfield	27%	62%	2%

Base: all who smoke/live with a smoker = 207

With only about 100 interviews per area, we are generally unlikely to see many differences in response that are statistically significant but prevalence was found to be even higher in Birkenhead (67%) than elsewhere (51% in Bootle/Litherland and 52% in West Everton/Breckfield). These disturbingly high levels of smoking justify the targeting of the campaign on this population group in these particular areas.

The data shows that of the smoking households, 33% of respondents or someone else smoked in the presence of children when they are at home - again the sample sizes are modest but the proportion smoking this way may be lower in Bootle/Litherland than in the other two areas.

If smoking and non smoking households are considered together, the data shows 20% of households had one or more parents smoking in front of the children at home.

Awareness of passive smoking

Almost the entire sample (97%) said that they were aware of the term 'Passive Smoking' - there was no significant variation by area or any other variable. Nearly nine-out-of-ten of those aware of the term were able to offer a correct definition of passive smoking (i.e. inhaling someone else's smoke), without prompting. The correct response was more likely to be given in Birkenhead (92%) than in West Everton/Breckfield (82%).

Attitudes to health issues

Respondents were read a number of statements about health issues and were asked to say to what extent they agreed or disagreed with each one. (see table three). There was a high level of agreement that "Children should avoid being in smoky places", with 75% of the overall sample expressing strong agreement.

Table 3
'For each one, please tell me how much you agree or disagree'

	A	B	C	D	E
'Children should avoid being in smoky places'	75 (62 in B'head North and 84 in Bootle)	17	3	2	2
'I don't mind people smoking around my children'	3	10	8	17	61*
'I avoid taking my children into smoky places'	47 (61 in West Everton but 35 in B'head North)	27	11	9	6
'I would not allow someone to smoke in my car' \diamond	64	11	4	8	12
'I only smoke outside the house' ∞	29	12	5	22	27
'Passive smoking doesn't worry me'	11 (17 in B'head North, 8 elsewhere)	15	5	16	51
'Passive smoking is a serious health risk for children' 79 (88 non-smokers but 73 smokers)		15	3	1	2

A = Agree strongly % • **B** = Tend to agree % • **C** = Neither, nor % • **D** = Tend to disagree % • **E** = Disagree strongly %
*73 non-smokers but 56 smokers. Base: all = 324 (except \diamond = all with a car and ∞ = all who smoke)

Across all sample groups, agreement was marked - for example, there was no significant difference in views between smokers and non-smokers. However, those living in Birkenhead North were less inclined towards strong agreement (62%) than were people in the two other areas (Bootle/Litherland 84% and West Everton/Breckfield 80%).

Only 13% of the total sample agreed that they "didn't mind people smoking around my children" - 78% disagreed with the statement. The only notable variation in views showed a lower level of agreement among smokers, though even here three-quarters disagreed with the idea.

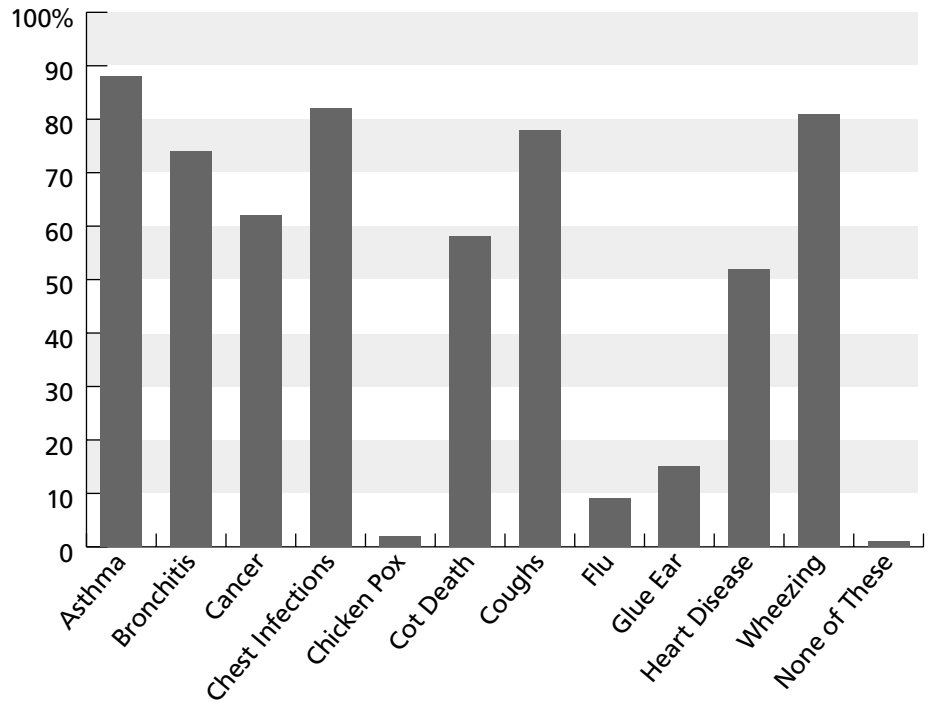
More than seven out of ten of those interviewed on the survey agreed that they "avoid taking my children into smoky places". Differences by area were clear with agreement varying from 65% in Birkenhead North to 81% in West Everton/Breckfield.

About a third of the sample were unable to answer the question about allowing anyone to smoke in the car, presumably on the grounds of not having a vehicle of their own. Of those with access to a vehicle, three-quarters agreed that they "would not allow someone to smoke in my car" - this view was held most strongly by non-smokers, though even two-thirds of smokers took the same line.

Four-in-ten smokers agreed that they "only smoke outside the house" - however, this still leaves about two thirds of all households in the survey having at least one parent who smokes around the home. Even though the samples of smokers in each of the three areas are very small, it is apparent that those in Bootle/Litherland are less likely to smoke around the home than are smokers in the other two areas.

Chart 1

Which, if any, of these health problems do you think might be caused by passive smoking?



A quarter of those interviewed agreed that “Passive smoking doesn’t worry me” — two-thirds disagreed with this notion. Interestingly, there was no variation in views between smokers and non-smokers but there were significant differences by area with Birkenhead North again showing less concern about smoking issues (36% agreement compared with 24% in West Everton/ Breckfield and 20% in Bootle/Litherland). While we have noted that a quarter of the sample were not worried by passive smoking, 97% of respondents agreed that “Passive smoking is a serious health risk for children”. There were no differences in attitudes held by smokers and non-smokers.

Health Impact of Passive Smoking on Children

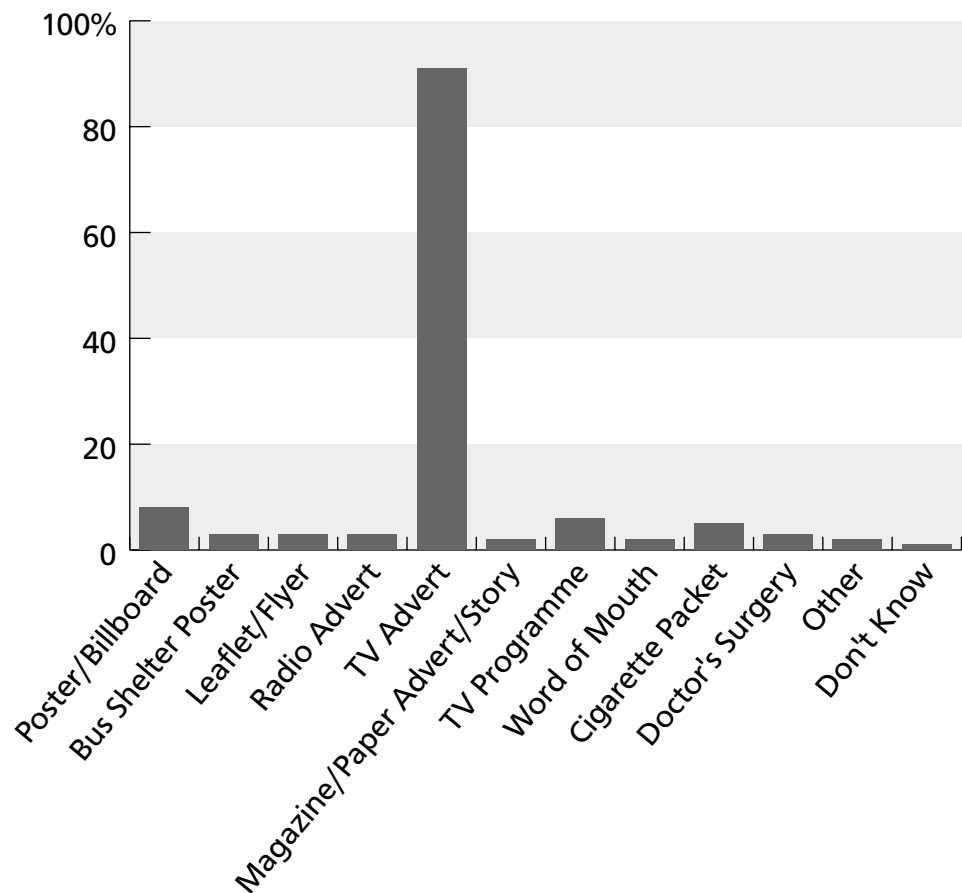
In order to assess knowledge, respondents were shown a list of health conditions and were asked to say which ones, if any, might be caused by passive smoking. Only 1% of the overall sample thought that none of the problems could be linked with inhaling someone else’s smoke. At the other end of the scale, 88% cited asthma, 82% chest infections and 81% wheezing. Respiratory problems also came fourth and fifth in the analysis (coughs and bronchitis with 78% and 74% respectively).

Interestingly, fewer people mentioned more serious or longer-term conditions such as cancer (62%), cot death (56%) and heart disease (52%). A small number of respondents noted other health problems including the (non-associated) ‘flu and chicken-pox. There were no significant differences by gender, age, area or smoking prevalence.

Chart 2

What have you seen or heard?

Base: all who have seen or heard any passive smoking publicity/advertising = 252



Advertising and Publicity - Unprompted Recall

Moving on to promotional activity, respondents were asked if they had recently seen or heard any publicity or advertising about passive smoking - just over three-quarters said that they were aware of some such activity. Nine out of ten of those who were aware of promotional work said that they had seen a television advert, while few people mentioned other sources. In part, this situation reflects popular recall of most campaigns in as much as recall of television adverts is often over-claimed. However, it should be remembered that the fieldwork on this project coincided with the launch of the national passive smoking campaign and its series of powerful TV adverts.

The numbers who spontaneously mentioned the media used on the Merseyside campaign were quite modest - 3% each for Radio City adverts, leaflets and bus-stop advertising. Of the eight people who mentioned bus-stop adverts (without prompting), seven lived in Birkenhead North and all eight who had seen something in the local surgery also lived in this part of the Wirral.

Advertising and Publicity Prompted Recall

Having established unprompted recall, the questionnaire went on to address prompted awareness, firstly by showing the three poster images - these are reproduced in the appendices to this report.

Respondents were also shown a copy of the leaflet used in the campaign and were given a short description of the advert used on Radio City ("a child coughing, with voiceover saying how much you can reduce the risks on children's health by not exposing them to passive smoking").

The highest recall for the five campaign media was for the Radio City advert which was recalled by one-in-five of the sample - the Blackboard image had the highest recall for the posters. The prompted recall figures for all media other than Radio City was significantly lower in Bootle than in the other two Sure Start areas covered in the survey. For all of the campaign material, recall was higher among smokers than non-smokers - 45% of smokers could remember at least one of the promotional materials compared with 33% of non-smokers. (see **Table 4** opposite)

A consistent strap line was used in all aspects of the campaign

('If you can't cut it out, put it out when the kids are about') and a direct question was asked to check on awareness of the slogan. Respondents were requested to think back to before the interview had taken place.

There was an even split between those who claimed to have previously heard of the slogan and those who said that the first time they had heard it was via the interviewer. Despite having lower levels of recall of most of the campaign materials, claimed prior awareness of the slogan was higher in Bootle/Litherland (59%) than in either of the other two areas (West Everton/Breckfield 44% and Birkenhead 45%). (see **Table 5** opposite)

Broad Impact of the Campaign

The interview concluded with another agree/disagree question, this time to try to get a feel for the actual impact of the campaign on all of the parents of pre-school children. More than eight-out-of-ten of those interviewed agreed that the adverts/leaflets "would make me think more deeply about the risks of passive smoking to my children". There were no differences in views between those who smoked and those who did not, but the overall level of agreement was lower in Birkenhead North (76%) than in West Everton/Breckfield (86%) or Bootle/Litherland (89%). The generally positive views with regard to the promotional campaign materials suggest that they were well-suited to this particular population group. (see **Table 6** opposite)

The high level of smoking prevalence identified justifies the targeting of this particular population. The simple fact that most pre-school parents in these areas are smokers demonstrates the need for more activity to facilitate change in parental behaviour to reduce children's exposure to passive smoking. The campaign materials seem appropriate and have the potential for considerable impact.

Experience elsewhere suggests that if smokers have to delay lighting up a cigarette, they are converting smoking from a subconscious reflex decision to a conscious decision. They have time to think about why they are smoking and this helps in cutting levels of consumption or stopping altogether.

More research is needed to explore the 'contradictions' in the data (e.g. the gap between knowledge and behaviour) and other issues such as the modest linkage between passive smoking and serious health conditions.

Table 4 • Have you seen this poster/leaflet before today?

	Total %	Birkenhead North %	Bootle/Litherland %	West Everton/Breckfield %
Blackboard	17	20	12	20
Stethoscope	12	15	8	14
Suggestions	12	16	5	14
Leaflet	10	15	4	13
Radio City advert	20	21	19	20
Any of the above	40	47	32	41

Base: all = 324. NB - figures shown are for those who have 'definitely' seen the material.

Table 5 • Before today, had you heard of the slogan 'If you can't cut it out, put it out when the kids are about'?

	Total %	Birkenhead North %	Bootle/Litherland %	West Everton/Breckfield %
Yes	50	45	59	44
No	49	54	40	54
Don't know	1	1	1	2

Base: all = 324

Table 6 • Please tell me how much you agree or disagree: the posters, leaflets and adverts have/would make me think more deeply about the risks of passive smoking to my children

	Total %	Birkenhead North %	Bootle/Litherland %	West Everton/Breckfield %
Agree strongly	58	49	67	58
Tend to agree	26	27	23	28
Neither, nor	6	7	8	5
Tend to disagree	6	12	3	5
Disagree strongly	2	6	0	2
Don't know	1	0	0	3

Base: all = 324

Objective Two

Who attended the training?

Response to the training was positive, 93 people attended from across Merseyside: **19 from Liverpool, 13 from Sefton, 30 from St Helens and Knowsley and 31 from Wirral.**

Participants represented a multiplicity of professional and other groups e.g.

Community parents, Health Visitors, Midwives, Project Development Workers (see appendix 4).

Methodology

The evaluation of the training was planned in two stages. Stage 1 being the completion of a reaction evaluation and stage 2 to revisit participants 8–12 weeks after they completed the training, to assess the impact of the training on practice (see appendix 5).

Reaction Evaluation

84 of the 93 participants completed the reaction evaluation, devised to test the learning outcomes, prior to their leaving the course; results were as follows:

1 = Definitely; **5** = Not at all

	1	2	3	4	5
● I understand the passive smoking campaign and it's aim.	80	4			
● I've considered the issues concerning children's exposure to passive smoking in the home.	75	9			
● I've increased my understanding of the health risks associated with passive smoking.	75	7	1	1	
● I can relate the cycle of change to the issue of passive smoking.	63	18	3		
● I feel able to use brief motivational interviewing techniques when discussing passive smoking with parents or carers.	53	24	6		
● I understand the 5-point plan.	63	20		1	
● I will incorporate the 5-point plan into my practice.	58	23	2		1
● I consider the pace of the session was:					
Too fast	Fast	Just right	Slow	Too slow	
1	6	76	1		
● I consider the content of the session was:					
Too difficult	Difficult	Just right	Easy	Too easy	
	2	78	4		

Participants were invited to comment on the training under the following headings:

Most useful and/or enjoyable aspect of the training

Five key themes were identified here and the comments quoted are representative of those made within each theme (for a full breakdown of comments see Appendix 6)

Course content:

“Understanding the health risks of passive smoking”

“Relating the Cycle of Change to passive smoking”

“Role play enabled me to see how the exercise would work in practice”

Quality of delivery:

“Clear information well presented”

Quality of information and resources:

“Information relevant and informative”

“Good resources to take away”

“Resources very useful and will be used in my sessions”

Working with parents or carers to reduce passive smoking exposure:

“Learning how to communicate in a non-confrontational way”

“Having an approach which does not expect parents to quit”

“Feeling able to support parents more actively”

Working with other professionals:

“Working with others from different backgrounds”

“Hearing the comments and experiences of others”

Least useful and/or enjoyable aspect of the training

13 participants made comments under this heading almost all centred on a dislike of role play. Whilst many participants felt the role play a positive experience there was an equal and opposite number who did not!

“Role play useful – but not enjoyable”

Other comments

Three additional themes were identified here:

Importance of the training:

“Tremendously impressed by the innovative ideas”

“This project would make an excellent national scheme”

Enjoyment and relevance:

“Important and relevant”

“Please continue the training people can learn a lot”

Incorporating into practice:

“I will put the five-point plan into practice”

Post Training Evaluation

Methodology

The post training evaluation was carried out by St Helens and Knowsley Clinical Governance Department.

A questionnaire was devised and disseminated, by post, to all Mersey wide staff who had undertaken the passive smoking intervention training. A total of 93 questionnaires were disseminated of which 67 (72%) questionnaires were returned, in the stamped addressed envelope provided, to the clinical governance department for collation and analysis.

Results

Which staff discipline do you belong to?

Health 21	4 (6%)
Health InK	2 (3%)
Health Promotion	1 (2%)
Health Visitor	8 (12%)
Midwife	7 (10%)
Nursery Nurse	6 (9%)
Occupational Health Nurse	1 (2%)
Parent Worker	1 (2%)
Practice Nurse	1 (2%)
School Health Support Worker	2 (3%)
School Nurse	4 (6%)
Smoking Cessation	5 (7%)
Sure Start	18 (26%)
Sure Start Health Visitor	1 (2%)
Sure Start Midwife	3 (4%)
Sure Start Nursery Nurse	1 (2%)
Ward Manager	1 (2%)
Not recorded	1(2%)

Prior to the passive smoking training would you have given passive smoking advice to patients/clients?

Yes	39 (58%)
No	18 (27%)
Not Sure	10 (15%)

As a result of the training have you given passive smoking advice to a greater number of patients/clients?

Yes	52 (78%)
No	6 (9%)
Not Sure	9 (13%)

If yes, please estimate the number of patients you have given passive smoking advice to as a percentage of your total face to face contacts.

0-10%	7 (12%)
11-20%	1 (2%)
21-30%	3 (5%)
31-40%	1 (2%)
41-50%	6 (10%)
51-60%	2 (3%)
61-70%	0 (0%)
71-80%	5 (9%)
81-90%	1 (2%)
91-100%	6 (10%)
Not Sure	26 (45%)

Not recorded x9

As a result of the training do you feel more confident in raising the issue of passive smoking with patients/clients?

Yes	65 (97%)
No	2 (3%)

Since the training do you feel you have a more detailed discussion with patients about the risk of passive smoking?

Yes	59 (88%)
No	4 (6%)
Not sure	4 (6%)

Did you find the passive smoking leaflets that you were given to hand out to patients/clients helpful in raising the issue of passive smoking?

Yes	61 (92%)
No	2 (3%)
Not given leaflet	1 (2%)
Not sure	2 (3%)

Not recorded x1

Will you incorporate the knowledge gained as a result of the training into your ongoing patient/client contacts?

Yes	64 (95%)
No	1 (2%)
Not sure	2 (3%)

We would welcome any further comments about the passive smoking training, which you think would be helpful.

- The training should be taken out to high schools and sixth form colleges x2.
- The training should be taken out to parent group workers x2.
- It is important to keep the trainees up to date with information re passive smoking.
- All training days should be multidisciplinary.
- Strategies should be drawn up to make children and parents aware of the risks of passive smoking.
- More information should be given to the public about where to go to give up smoking.
- The training session should have been longer.
- I wasn't keen on the role plays used at the training session.
- A training event should be organised for all child health care professionals.
- The training should be opened up to occupational health specialists.
- There is too much information on the passive smoking leaflets. Patients with poor literacy won't be able to read them.

Overall the audit findings indicate that health professionals benefited from undertaking the passive smoking intervention training and that it has had a direct impact on their day-to-day patient care, with:

- 78% of respondents stated they had given passive smoking advice to more patients/clients as a result of the training.
- 97% of respondents stated they felt more confident in raising the issue of passive smoking with patients/clients as a result of undertaking the training.
- 88% of respondents stated they had a more detailed discussion with patients/clients about passive smoking as a result of the training.
- 92% of respondents stated they felt the passive smoking leaflets were helpful in raising the issue of passive smoking with patients/clients.
- 95% of respondents stated they would incorporate the knowledge gained during the training into their ongoing patient/client contacts.

Tutor's Impressions of the Training

Comments during training were positive and delegates participated enthusiastically. Knowledge of the health risks associated with passive smoking was mixed, but overall appeared lower than had been anticipated.

Participants were very skilled in assessing children's exposure to passive smoking and their input has added considerably to this aspect of the training.

Many staff, particularly those working in the secondary care sector, had no knowledge of motivational interviewing techniques; those who did failed to recognise its potential in relation to the issue of passive smoking.

Participants recognised raising the issue of children's exposure to passive smoking as difficult and many expressed relief at being offered an alternative to recommending cessation which they believed to be potentially damaging to their relationships with parents.

Because the training offered what was perceived to be an effective means of protecting children from the health risks of passive smoking, without focusing on cessation, participants expressed enthusiasm in incorporating the Five Point Plan into their practice.

The leaflets and posters, which underpin the campaign, were seen as providing an excellent opportunity to raise the issue.

The training offered those working with the target audience a realistic alternative to use with parents or carers when giving up smoking was not a viable option, and as such the scope for use in practice is enormous

Providing this short training session increased the skills and knowledge of those working with the target group and significantly increased the likelihood of them intervening with parents and carers both in the short and long term.

Finances

The total cost of the project: £28,000, excluding report and distribution. For full details see Appendix 7.

Difficulties and Restraining Factors

Planning

- The time allocated for delivery of all aspects of the intervention was unrealistic.
- Within the region there appears to be a lack of individuals or organisations with the expertise to conduct an evaluation and as a result no pre-campaign data was collected and the group had considerable difficulty finding someone to conduct the post campaign media evaluation.
- Whilst this was not the case in all instances the group did experience some difficulty in engaging partners. This may be because at no time prior to the campaign were partners involved in the planning of the intervention.

Staffing

- Once the operational aspect of the project was established the larger group, particularly those with a strategic input, ceased to meet. This led to communication difficulties.
- At no point did the group anticipate the demands on operational staff's time.
- A number of staff roles changed throughout the planning and implementation of the project which has caused considerable difficulty in term of continuity and time commitment.

Finance

- The £20,000 was insufficient to operate a campaign of this size.
- Communication problems around financial management has meant the group experienced difficulties in accessing the funds.

External Factors

- The evaluation fieldwork for this project coincided with the launch of the national passive smoking campaign and its series of powerful TV adverts, this may have had a bearing on the evaluation results obtained.

Recommendations

Objective One

Recommendation One

There should be follow up research that is qualitative in nature, making use of either individual interviews or group discussions to further explore the contradictions in the data.

Recommendation Two

The recent adverts should be tested again in any qualitative work to assess which images respondents found most powerful.

Recommendation Three

Any future repeat of the campaign should involve 'pre' as well as 'post' interviewing to demonstrate the impact more clearly than was possible on this occasion.

Objective Two

Recommendation Four

The training should be rolled out to appropriate staff members across Merseyside and a train the trainer pack should be developed to enable others to deliver the intervention.

Recommendation Five

Where possible this half-day module should be built into mandatory training and education courses for key professional and voluntary personnel.

Recommendation Six

More research should be implemented to assess the impact of brief interventions around passive smoking on parental smoking behaviour.

Further Recommendations

Recommendation Seven

Partners must be consulted prior to campaign planning to ensure that their needs are met and a sense of ownership, co-operation and commitment is achieved.

Recommendation Eight

Funding needs to be identified to increase the scope of the campaign by rolling it out over a larger area and to conduct further research as identified.

Recommendation Nine

The campaign should be considered as a model for regional and / or national action.

Recommendation Ten

The campaign should be entered in appropriate Health Care Communicators Award Schemes.

Recommendation Eleven

Disseminate the campaign outcomes to other alliances.

Recommendation Twelve

Communication between those working at ground level and within the Tobacco Policy Unit at the Department of Health must be improved.

References

- 1 A report of the Surgeon General. Reducing the Health Consequences of Smoking: 25 years of progress. US Dept. of Health and Human Services, 1989.
- 2 Report of the Scientific Committee on Tobacco and Health. Department of Health, 1998.
- 3 Bonita R, Duncan J, Trudsent T, Jackson R & Beaglehole R. Passive smoking as well as active smoking increases the risk of acute stroke. *Tobacco Control* 1999; 8: 156-160.
- 4 Otsuka R, Wantanabe H, Hirata K, Tokai K, Muro T et al. Acute effects of passive smoking on coronary circulation in health young adults. *Journal of American Medical Association* 2001:436-441.
- 5 General Household Survey (1998) Office of National Statistics. 1999.
- 6 Javris MJ. Children's exposure to passive smoking: survey methodology and monitoring trends. Background Paper. 1999. Available from: Tobacco Free Initiative: www.who.int/toh/TFI.consult.htm (accessed 7 may 2000).
- 7 Smoking and the Young, Royal College of Physicians, 1992.
- 8 Adams EK, Melvin C, Merritt R and Worrall B. The cost of environmental tobacco smoke: an international review, 1999. Available from: Tobacco Free Initiative www.who.int/toh/TFI/consult.htm (accessed 7May 2000).
- 9 ASH. Passive Smoking: The Impact on Children. Update 2002. Available from www.ash.oeg.uk/passive/kidsbrief.
- 10 Jarvis M, Goddard E, Higgins V, Feyerabend C, Bryant A & Cook D. Children's exposure to passive smoking in England since the 1980s: cotinine evidence from population survey. *British Medical Journal* 2002:32:343-345.
- 11 Lund K, Vertio H & Helgason A. To what extent do parents strive to protect their children from environmental tobacco smoke in the Nordic Countries? *Tobacco Control* 1998:7.
- 12 Ayanian J and Cleary P. Perceived risks of heart disease and cancer among cigarette smokers. *Journal of American Medical Association* 1999:281:1019-1021.
- 13 Mac Morgan J. NEAT Marketing PR campaign on passive smoking. Personal Communication, 2002.
- 14 Anderson M. Smoke-free Environment for Children, George the Giraffe Project. Norwegian Cancer Society, 2002.
- 15 Prins T. (2002) Strategies of Communication to the Public, Dutch Cancer Society, The Netherlands.
- 16 Crone M, Reijneveld S, Willemsen and Hira Sing R. Parental education on passive smoking in infancy does work. *European Journal of Public Health*: accepted 2002.
- 17 Howell M, Zakarian, Matt G, Hofstetter C, Baernet J and Pirkle J. Effect of counselling mothers on their children's exposure to environmental tobacco smoke: randomised controlled trial. *British Medical Journal* 2002:321:337-342.
- 18 Living in Britain: Results from the 1996 General Household Survey, ONS, 1997.
- 19 Crone MR, Hirasing RA, Burgmerijer R. Prevalence of passive smoking in infancy in the Netherlands. *Patient Educ Couns*. 1994;39:149-53.
- 20 Department of Health. Drug use, smoking and drinking among young people in England 2001. Department of Health, press release, 15th March 2003.
- 21 Prochaska J.O. and DiClemente C. (1982) Transtheoretical Therapy: Towards a integrative model of change. *Psychotherapy: Theory, Research and Practice* 14 (3) 276-288.

Appendix 1

Campaign Materials (see back cover for colour versions)



Appendix 2

Radio City Script

Client: Smoke Free Merseyside
Date: 22.01.03 **Job No:** c 4230
Duration: 30 seconds **Title:** Choked
Writer: Sam

MVO Child: Young child coughing
FVO: Warm, sincere and reassuring
MVO: Friendly and warm

MVO Child: Child coughing.

FVO: By waiting until the kids have gone to bed, by not lighting up when they're in the car and by smoking in another room, you can significantly reduce the risks of harming your children through passive smoking.

Music in: Minimal and gentle.

MVO: Smoking; if you can't cut it out, put it out when the kids are about.

FVO: For more information on passive smoking call NHS direct on 0845 46 47.

Appendix 3

NOP/450193 Questionnaire issue 4, 10 July 2003

SureStart Areas

Hello, my name is [] from NOP Research Group. We are conducting a short survey about some public issues in this area of Merseyside.

QA *If in-street:* Can I just check, do you live in this area? (*Show map*)

Yes: *Continue with interview*

No: *Close and do not count for quota*

Don't know: *Close and do not count for quota*

QB Are you the parent/step-parent/carer of any children aged 5 or under who live with you at home?

Yes: *Continue with interview*

No: *Close and do not count for quota*

Q1 Do you or does anyone else who lives in your home smoke?

Code all that apply

Yes, respondent: *Ask Q2*

Yes, someone else: *Ask Q2*

No, no one smokes: *Go to Q3*

If yes

Q2 And do you/they smoke in the presence of children when they are in the home?

Yes/No/Don't know

Ask all

Q3 Have you ever heard of the term 'passive smoking'?

Yes: *Ask Q4*

No: *Go to Q5*

Don't know: *Go to Q5*

If yes

Q4 What do you think 'passive smoking' means? *Do not prompt*

Breathing in/to breathe in/inhaling someone else's tobacco smoke

Something else *Please specify*

Don't know

Ask all

Q5 (Passive smoking means breathing in someone else's tobacco smoke). Here are some statements that people have made about passive smoking:

Showcard 'A'

For each one, please tell me how much you agree or disagree.

Agree strongly/tend to agree/neither agree nor disagree/tend to disagree/disagree strongly (with not applicable as extra code on the questionnaire, not showcard)

A Children should avoid being in smoky places

B I don't mind people smoking around my children

C I avoid taking my children into smoky places

D I would not allow someone to smoke in my car

E I only smoke outside the house

F Passive smoking doesn't worry me

G Passive smoking is a serious health risk for children

Q6 Here are some health problems that can affect children: *Showcard B* - Which, if any, of them do you think might be caused by passive smoking, i.e. other people smoking near young children? *Code all that apply*

Asthma/Bronchitis/Cancer
Chest infections/Chicken pox
Cot death/Coughs/Flu/Glue ear
Heart disease/Wheezing/
(None of these)/(Don't know)

Q7 Have you recently seen or heard any publicity or advertising in connection with passive smoking?

Yes: *Ask Q8*/No: *Go to Q9*
Don't know: *Go to Q9*

If yes

Q8 What have you seen or heard?

Anything else? *Do not prompt*

Seen poster/billboard (not specific)
Seen poster/ on bus-shelter
Seen leaflet/flyer about passive smoking
Heard advert on the radio/Radio City
Saw advert on television
Saw advert in the paper
Saw advert in magazine
Saw article/story in the paper
Saw article/story in magazine
Saw programme on the television
Word-of-mouth/someone mentioned it
Other *Please specify*
Don't know

Ask all

Q9 *Show poster A (Blackboard)*

Have you seen this poster before today? *Probe for code*

Yes, definitely/Yes but not sure
No, definitely haven't seen/Don't know

Q10 *Show poster B (Stethoscope)*

And have you seen this poster before today? *Probe for code*

Yes, definitely/Yes but not sure
No, definitely haven't seen/Don't know

Q11 *Show poster C (Suggestions)*

Have you seen this poster before today? *Probe for code*

Yes, definitely/Yes but not sure
No, definitely haven't seen/Don't know

Q12 *Show leaflet*

And have you seen this leaflet before today? *Probe for code*

Yes, definitely/Yes but not sure
No, definitely haven't seen/Don't know

Q13 Have you recently heard an advert on Radio City featuring a child coughing, with a voiceover saying how much you can reduce the risks on children's health by not exposing them to passive smoking? *Probe for code*

Yes, definitely/Yes, but not sure
No, definitely not/Don't know

Q14 Before today, had you heard of the slogan 'If you can't cut it out, put it out when the kids are about'?

Yes/No/Don't know

Q15 *Showcard 'A' again* Please tell me how much you agree or disagree with the following statement. 'The posters, leaflets and adverts we have talked about have/would make me think more deeply about the risks of passive smoking to my children.'

Agree strongly/Tend to agree/Neither agree nor disagree/Tend to disagree
Disagree strongly

Q16 *Interviewer code respondent sex*

Male/Female

Q17 Are you yourself in paid work at all nowadays?

Yes (full or part-time)/No

Q18 And finally, what was your age last birthday?

16-24/25-34/45-54/55+

Thank and close

Appendix 4 who Attended the Training?

Recruited from:	Liverpool	St Helens and Knowsley	Sefton	Wirral
Midwife	3	1	3	4
Early Years Co-ordinator	1			
School Nurse	2			
Community Parents	7	4		
Deputy Programme Co-ordinator (Sure Start)	1			
Health Visitor	1	5	1	2
Nursery Nurse	1	3	2	
Outreach Worker	1			
Community and Family Support Worker	1			2
Development / Project Worker		7	1	1
Jobs, Education and Training Officer / Tutor			1	1
Centre / Programme Manager			2	2
Administration and Support Worker			1	
Early Years Worker			1	
Family Health Nurse			1	
Community Health Worker				2
Play and Learning Practitioners				2
Smoking Cessation Specialist				2
Asthma Link Nurse				1
Occupational Health Nurse				1
Children's Nurse				6
Drug Company Representative				1
Ward Manager				2
Health Care Assistant				1
Toy Library Supervisor / Worker		4		
Community Nurse		1		
School Health Support Worker		2		
School Nurse		3		1
Unknown	1			
Totals per area	19	30	13	31
Total all areas: 93				

Appendix 5

Passive Smoking Campaign

Thank you for attending the recent passive smoking training course. In order to assess the impact of the training we would be grateful if you would comply and return the following questionnaire by 15th September 2003.

1 Which staff discipline do you belong to?

Health InK Health 21 Staff
Health Visitor Midwife
Nursery Nurse Practice Nurse
School Nurse Sure Start

Other (please state)
(Please tick appropriate box)

2 Prior to the passive smoking training would you have given passive smoking advice to patients/clients?

Yes No Not Sure

3 As a result of the training have you given passive smoking advice to a greater number of patient/clients?

Yes No Not Sure

4 If yes please estimate the number of patients you have given passive smoking advice to as a percentage of your total face to face contacts

[]% Not Sure

5 As a result of the training do you feel more confident in raising the issue of passive smoking with patients/clients?

Yes No Not Sure

6 As a result of the training do you feel you have a more detailed discussion with patients about the risk of passive smoking?

Yes No Not Sure

7 Did you find the passive smoking leaflets that you were given to hand out to patients/clients helpful in raising the issue of passive smoking?

Yes No Not Sure

8 Will you incorporate the knowledge gained as a result of the training into your ongoing patient/client contacts?

Yes No Not Sure

9 We would welcome any further comments about the passive smoking training which you think would be helpful.

Thank you for taking the time to complete the questionnaire.

Please return the questionnaire either by mail or by fax to:

Mark Wilson
Clinical Governance Department
Knowsley Primary Care Trust
Moorgate Point
Moorgate Road
Knowsley Industrial Estate
Knowsley L33 7XW

Fax: 0151 477 4779

Closing Date: 15th September 2003

Appendix 6

Reaction Evaluation; Summary of Comments

Most useful and/or enjoyable aspect of the training

Course Content

- 2 x all of it.
- 2 x excellent training.
- 9 x role play very good.
- Role play enabled me to see how the exercise would work in practice.
- Role play – introducing subject into conversation.
- 4 x finding out about passive smoking.
- Understanding the health risks of passive smoking.
- Learnt more of consequences of passive smoking.
- Identifying the damage that can be done.
- 5 x increased my awareness of the dangers and issues.
- Confirming health risks and consolidating info already known.
- 2 x new information.
- 2 x Case studies very useful.
- 6 x group work very good.
- 2 x brainstorming.
- 3 x adaptation/understanding of the Cycle of Change to passive smoking.
- 4 x Understanding/recap motivational interviewing.
- Relating passive smoking to the cycle of change and motivational interviewing and seeing how this can be implemented into my day to day role.
- 3 x 5 point plan.
- 5 x information relevant and informative.

Quality of Delivery

- Trainer went at an approachable pace.
- Variety of teaching methods.
- Clear information – well presented.
- Varied approach.
- No jargon.

Quality of Information and Resources

- Statistics.
- Slides and sharing information.
- Simple literature.
- 2 x Handouts/teaching pack very useful.
- Resources very useful and will be used in my sessions.
- Info and resources very useful.
- Good resources to take away.

Working with Parents or Carers to Reduce Passive Smoking Exposure

- 2 x feeling able to support parents more actively/more positively.
- Useful hints and tips for discussing passive smoking with clients.
- Discussing how to address problems, being able to empathise with parents without being judgemental.
- Learning new strategies to deal with clients.
- Learning how to communicate in non-confrontational way.
- Learning that I can't change the world! But can introduce new ideas and be part of a group of professionals who promote good health.
- Having an approach which does not expect parents to quit.
- Feeling motivated to do something.

Working with other Professionals

- Group interaction.
- 3 x Group discussion.
- Hearing comments and experiences of others.
- Meeting other health professionals.
- Working with others from different backgrounds.
- Chance to talk with others about experiences.

Least useful and/or enjoyable aspect of the training

- 10 x role play.
- Role play useful – but not enjoyable.
- Going through all the slides – although I did like the handouts.
- Would have liked more time to practice.

Other Comments

Course Content

- The role-play was surprisingly useful.
- The session has raised my awareness of health issues related to passive smoking.
- Very informative x 9.
- Very interesting x 4.
- 2 x very good.

Quality of Delivery

- Very well presented.
- Well presented x 2.
- Well presented, clear, informative and well paced.
- Excellent presentation.
- Easy to listen to and understand x 2.
- Tutor made the session enjoyable and informative.
- Interactive.
- Clear and precise.
- 2 x well presented and relaxed – I got a lot out of it.

Quality of Resources and Information

- Literature will be useful and will pass it on.
- Clear and concise information.
- Would like a copy of the presentation.

Working with Parents or Carers to Reduce Passive Smoking Exposure

- A valuable session highlighting the issues and demonstrating how they can be raised with clients.

Importance of the Training

- Important and enjoyable x 4.
- Positive messages.
- Tremendously impressed by the innovative ideas.
- Wish the team every success, this project would make an excellent national scheme, which would improve the health of the nation.
- Carry on with the campaign and good luck with it.

Enjoyment and Relevance

- Enjoyed the session x 4.
- Updated my knowledge.

Incorporating into Practice

- I feel I will put this knowledge into practice.
- I have gained some useful ideas to take back to my practice area.
- I will put the 5 Point Plan into practice.
- Feel more confident about passing on info re passive smoking.
- Excellent, very useful will put into practice.

Appendix 7 Financial Breakdown

Funding Providers **Amount**
Department of Health **28K**
Wirral **4k**

Description	Quantities	Cost £
Advertising		
Design Development		in kind
Adshel – Bus Shelters	4 weeks	6,516.55
Radio Script		387.75
Radio Air Time	2 weeks	5,690.17
Design development		in kind
A3 Posters	2000	740
A5 Leaflets	52500	795.60
Newspaper – Bootle Times	4 weeks	604.80
Design Development	1 advert a week	in kind
Training		
Translation of Netherlands Five Step Plan by DoH		in kind
Training Development and delivery		in kind
Folders	400	615
Venue	2	600
Crèche Facilities – places	3	36
Evaluation		
Market Research	3 areas	11,632.50
Training by St Helens and Knowsley Clinical Governance unit	4 areas	in kind
Total		27,618.37

