Evaluation of

Training to Reduce children's exposure to Second Hand Smoke:

a report commissioned by NHS Greater Glasgow and Clyde

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Terminology

Throughout this report, the term participants will be used to refer to people who attended the training.

The term respondent is reserved to refer to those participants who have completed questionnaires.

Individuals who took part in a follow up interview or focus group are referred to as interviewees and focus group participants respectively.

Where the term significant difference is used, this denotes a statistically significant difference. Further details on the reporting of significance are provided in the Findings chapter.

Disclaimer

The opinions expressed in this report are those of the author and are not necessarily those of NHS Greater Glasgow and Clyde

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Particular thanks go to Brenda Friel for overseeing this commission, and for her part in us achieving such magnificent response rates in the three surveys.

And finally, the credit for the enormous amount of work involved in collating and analysing all the survey data goes to Margaret McGranachan who provided these not only with a scarily high level of competence but with her usual good humour!

Executive Summary

Background

In 2009, NHS Greater Glasgow and Clyde planned and co-ordinated the roll out of training which aims to reduce children's exposure to second hand smoke (SHS) across its CH(C)Ps and maternity services.

This training aims to:

- increase awareness about the effects of SHS, particularly to children's health;
- equip participants with the knowledge and skills to help them carry out brief interventions with parents/carers to help them reduce children's exposure to SHS inside and outside the home; and
- familiarise participants with 'the five-point plan' as a framework for the brief intervention. The five-point plan involves: assessing exposure to second hand smoke; raising the issue; assessing readiness to change; taking action according to readiness to change; and follow up.

Jacki Gordon + Associates was commissioned to conduct an evaluation over the first few months of the training's rollout across its CH(C)Ps.

Evaluation aims

The evaluation assessed whether the training was implemented as intended and whether it achieved its intended outcomes. It also aimed to identify factors associated with positive outcomes.

Evaluation methods

The evaluation involved:

- consideration of the records held by NHS Greater Glasgow and Clyde on number of sessions run in each CH(C)P and attendance levels at each of these events;
- questionnaires for completion by all participants before attending the training, at the end of the training, and at three month follow up;
- four follow up depth interviews and four follow up focus groups with a sample of participants who had attended the training in the preceding four to eight months.

Key Findings

The training was delivered to each of the CH(C)Ps, with the overwhelming majority achieving the targeted number of sessions and participants, albeit over a slightly extended time period than initially planned.

The profile of those attending the training was consistent with the target groups that had been identified at the outset as the key professionals to be targeted: 47% described themselves as a health visitor, staff nurse, dental support worker, oral health promoter, or a PACT worker.

Prior to the training, confidence levels were low both in terms of knowledge about SHS, and ability to carry out the various components of a brief intervention on this topic.

The training was extremely effective in increasing knowledge about SHS and its effects. As a consequence, participants felt more confident to talk about SHS.

In practice, the extent to which increased knowledge and confidence translated into increased behaviour was found to be highly dependent on role: while there was a general increase in participants feeling that they were more likely to talk about SHS to families (i.e. raise awareness), the potential to intervene and support families in making any changes was largely restricted to those performing a health visiting role.

The leaflet recently produced by NHS Greater Glasgow and Clyde ('Keep your family safe from second hand smoke') was valued and described not only as a useful source of information, but as creating an opportunity to talk to families about SHS.

Key recommendations

Future training should be targeted at those who have a very clear role in proactively assessing children's exposure to SHS and who are in a position to offer follow up encouragement and support to those families who experience particular challenges in making their homes and cars smoke free.

Much of the training content should be preserved. However, there may be merit in tailoring it to better meet the needs of participants, particularly in view of what type of intervention is possible/appropriate to their role.

Those whose roles permit them to do more than simply raise awareness, and who are able to deliver a brief intervention (including follow up), may benefit from some additional content on how to tackle the topic in challenging circumstances.

There will be an ongoing need to ensure that the training provides best available evidence on how to reduce the effects of SHS. Thus, wherever possible, participants need to be told what measures families can take to reduce risk, including how to reduce the risks associated with third hand smoke.

If feasible, it would be useful to provide follow up information to participants to not only reinforce the learning, but to keep them abreast of new evidence.

1. Introduction

In 2009, NHS Greater Glasgow and Clyde planned and co-ordinated the roll out of training which aims to reduce children's exposure to second hand smoke (SHS) across its CH(C)Ps and maternity services.

This training programme has been developed by the Roy Castle Lung Cancer Foundation and takes the form of:

- a training for trainers' component lasting 2 days; and
- an associated pack to structure and support those trained so that they in turn can subsequently deliver half day sessions to equip professionals (and others if appropriate) in reducing children's exposure to SHS.

NHS Greater Glasgow and Clyde commissioned Jacki Gordon + Associates to evaluate this latter element of the training. This is the report of that evaluation.

1.1 About Second Hand Smoke

Second hand smoke (SHS) comprises exhaled mainstream smoke and side-stream smoke from the lit end of a cigarette. Due to the fact that it contains a noxious mix of toxins and human carcinogens and the strength of evidence indicating its role in causing or exacerbating a range of health problems, SHS has been classified as a significant public health hazard[i]. Recognition of the adverse health effects of SHS underpinned the Smoking, Health and Social Care (Scotland) Act 2005 which came into force on 26th March 2006. This legislation prohibits smoking in most enclosed public places and workplaces.

There are a number of exemptions to the legislation. These include residential accommodation, psychiatric units and prisons. Notably, there are no legislative restrictions on whether people smoke in the privacy of their own homes and cars. Thus, the home and car continue to be sites of potentially high SHS exposure[ii].

The most recent Scottish Health Survey[iii] indicates a substantial decline in non-smokers' exposure to SHS both in their own homes and those of others. While this reduction is welcome, particular concerns have been raised regarding the substantial exposure that is still experienced by babies and children in those households with smokers, and indeed those living in disadvantaged households more generally. [iv].

SHS exposure among children has been linked to a range of health problems. These include: lung infections and decreased lung function (e.g. coughing, wheezing); increased risk of asthma and other respiratory problems; meningitis; and middle ear disease (e.g. glue ear). Furthermore, and more seriously still is the association of family and household smoking with sudden infant death syndrome (SIDS).

The most important determinants of SHS exposure in children is whether their parents or carers smoke and whether smoking is permitted in the home. In comparison with children whose parents do not smoke, SHS exposure is 'typically' approximately three times higher where the father smokes, six times higher if the mother smokes and nearly nine times greater if both parents smoke[v].

There is a strong gradient in smoking prevalence across deprivation deciles: the Scottish Health Survey confirms the extent to which smoking behaviour is heavily socially patterned, with National Statistics socio-economic classification, income and area deprivation all demonstrating significant independent associations. Such patterning by deprivation has been reported in expectant women and postnatally. In 2005, 6.3% of women living in the least deprived quintile (fifth) smoked compared with 35.8% of those in the most deprived quintile at their antenatal booking visit. At the first domiciliary post-natal visit, this prevalence has been found to be only slightly reduced: most smokers continue to smoke throughout their pregnancy and some of those who give up restart immediately after birth[vi].

Thus, the burden of morbidity and mortality associated with exposure to SHS in the home is likely to be more commonly experienced by those children living in deprived circumstances.

1.2 The training intervention

The Roy Castle Lung Cancer Foundation has produced a training pack called 'Reducing Children's Exposure to Second Hand Smoke'.

It promotes reducing children's exposure to SHS through measures such as keeping children's playing, sleeping and eating areas completely smoke free, and encouraging any smoking to be done outdoors, away from the children. Where such measures are not possible, the training recommends that smoking should be limited to one well-ventilated room in the home. The training also promotes the avoidance of smoking in the car.

In 2009, NHS Greater Glasgow and Clyde together with its CH(C)Ps identified this training pack as one that they would like to use to complement their wider suite of initiatives tackling tobacco use.

The Roy Castle training comprises a training for trainers' component. This provides the basis for subsequent delivery of a training session, approximately four hours' long, that aims to:

- increase awareness about the effects of SHS, particularly to children's health;
- equip participants with the knowledge and skills to help them carry out brief interventions with parents/carers to help them reduce children's exposure to SHS inside and outside the home; and
- familiarise participants with 'the five-point plan' as a framework for the brief intervention. The five-point plan involves the following steps: assessing exposure to second hand smoke; raising the issue; assessing readiness to change; taking action according to readiness to change; and follow up.

1.3 Planning the rollout of the training and its subsequent monitoring and evaluation

Prior to rolling out this training in its health board area, NHS Greater Glasgow and Clyde commissioned Jacki Gordon + Associates to help them develop a monitoring and evaluation framework as a basis for subsequently assessing whether the training was implemented as intended and whether it was effective.

In order to develop this framework, Jacki (hereafter referred to as 'the consultant') led the key stakeholders from the Health Board and CH(C)Ps through a process that required them to think through what changes they hoped the training would effect. Importantly, these discussions took as the starting point, what they hoped the training would achieve in the medium and long term. Thus, instead of thinking of the training simply in terms of its immediate learning outcomes, the stakeholders considered how the training might plausibly effect changes in the numbers of children exposed to SHS in the home and car, *and then work backwards from this* i.e. to think through (in a critical manner) how the training programme might (logically) lead to reduced exposure in children under the age of five years.

As part of this process, stakeholders were required to consider key assumptions underpinning their theory of change i.e. their theory of how the training was going to lead to the changes they envisaged.

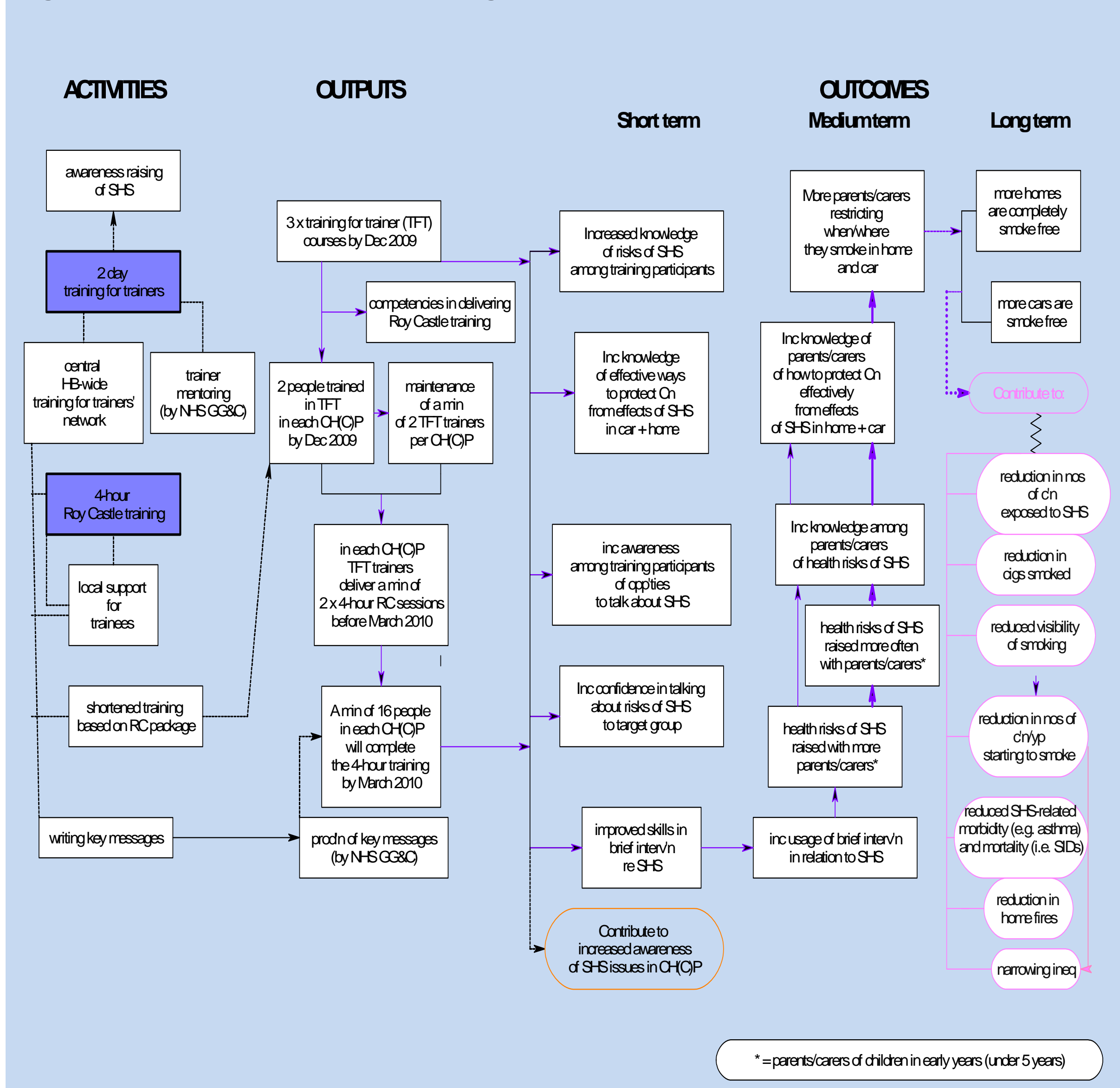
On the basis of these discussions, the stakeholders agreed the short and medium term outcomes (i.e. changes) that they hoped the training would bring about, and for the first year, how the training would be rolled out to achieve these. Their views or 'theory' were then recorded in the form of a logic model. This is provided in Figure 1 (over).

There are a number of noteworthy issues to highlight here.

First, there was agreement that the intention was that the training reduce exposure to SHS among children under the age of five years. The implication of this was that the training should be targeted at those who work with that age group.

Figure 1:

Logic model for rollout of SHS training in NHS GG&C (year one)



As previously mentioned, a number of key assumptions were highlighted as underpinning the model too. These included the following:

- Participants will benefit from the training i.e. they will not already have detailed knowledge about SHS and its effects, and skills in delivering brief interventions to parents/carers regarding SHS in the home.
- If participants are given the information and some skills in brief intervention, they will go on to use them (as appropriate).
- If families/individuals limit smoking in their home and cars, this increases the likelihood of them subsequently making their homes and cars (completely) smoke free.
- As the Roy Castle training is premised on the notion that families will be followed up, those targeted for the training will be in regular contact with families including being able to follow them up.
- The core messages (once developed) will reflect best available evidence (and therefore ensure that parents/carers understand the limited effectiveness of restricting rather than eradicating smoking in the home/car).
- SHS messages are more likely to be accepted and acted upon if the message carrier is considered to be a credible and authoritative source: examples include health visitors, practice nurses, community midwives and pharmacists.
- Targeting should be informed by consideration of risk: those working in areas of high deprivation and/or have contact with children with conditions such as asthma and with (recurrent) otitis media are examples of 'best buys' given the inevitable constraints in terms of the numbers that can be trained.
- The implementation/rollout of the training is 'nested' within and supported by a broader range of strategic activity addressing SHS in the CH(C)Ps/ NHS GG&C.

Across many of the CH(C)Ps, some concern however was expressed about the planning process being overly prescriptive in terms of who should be 'allowed' to attend the training. In response to these concerns, NHS Greater Glasgow and Clyde identified a fairly broad range of professionals for targeting in the first instance. These were as follows: health visitors; practice nurses; dental support workers; family support workers; oral health promoters; dental nurses; and 'Parents and Children Together' teams (PACTs). However there was an acknowledgement that CH(C)Ps may wish to extend the training to others too. As such, some stakeholders felt that anyone in contact with families of young children is well placed to intervene and reduce exposure to SHS.

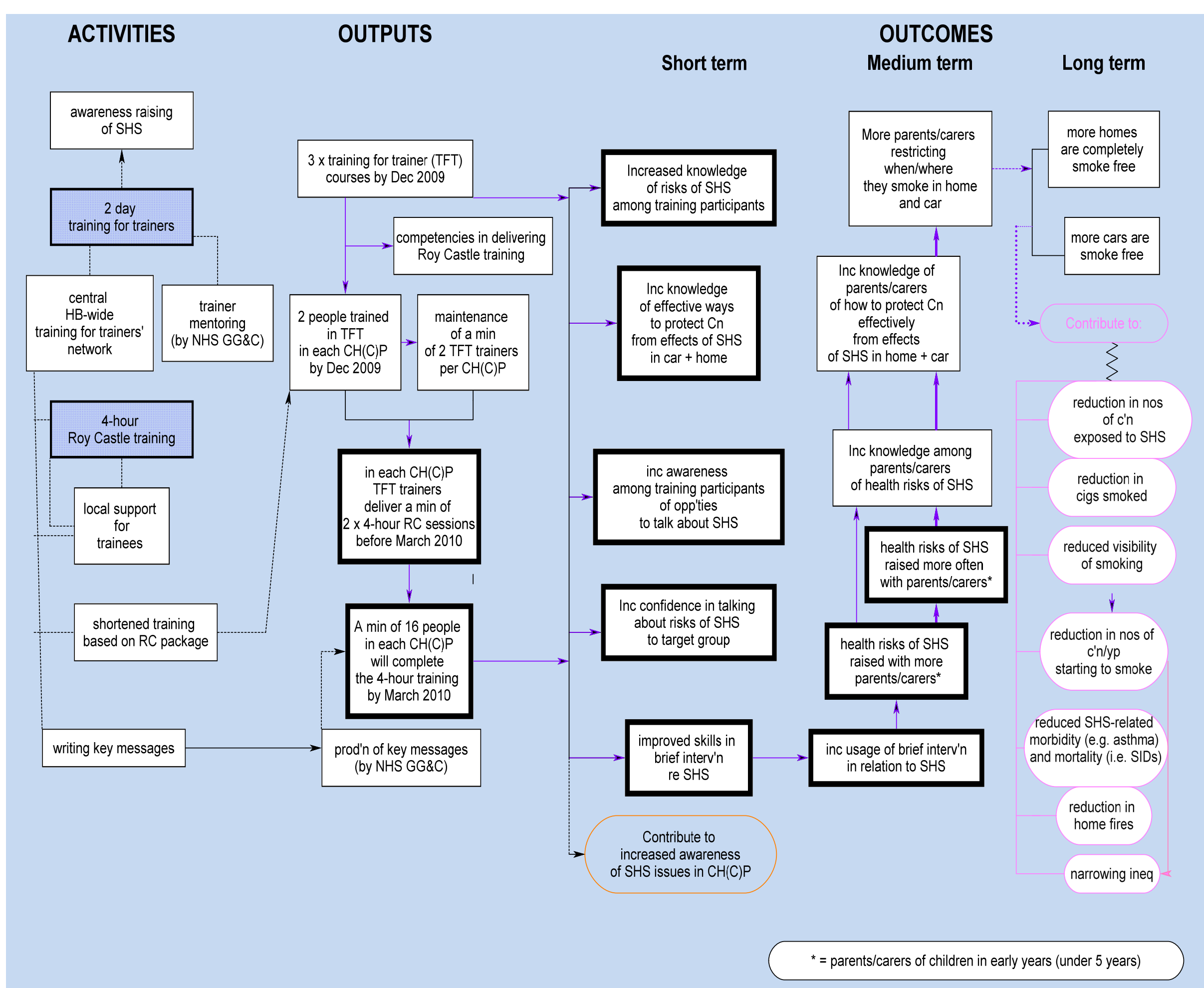
The logic model and these assumptions provided the basis for a series of recommendations on how the training could be monitored and evaluated in the short term i.e. over the first year to 18 months of the training's roll out. A paper on this was produced and is available on request from Smokefree Services, NHS Greater Glasgow and Clyde.

The current evaluation is based on the stakeholders' prioritisation of the options outlined in that paper.

1.4 Aims and key objectives of this evaluation

Broadly speaking the current evaluation aims to assess the extent to which the training programme has been implemented as intended, the extent to which the key assumptions listed 'hold true' and whether it is achieving its anticipated short term and selected medium term outcomes. More specifically, the evaluation focuses on the extent to which the outputs and outcomes in the heavy-lined boxes in Figure 2 have been achieved.

Figure 2: Outputs and outcomes addressed in current evaluation



The evaluation is guided by the principles of Realistic Evaluation[vii].This theoretical approach acknowledges that things seldom 'work' or do 'not work', and instead seeks to uncover the particular circumstances associated with better and worse outcomes.

Thus the current evaluation is not restricted to only assessing whether the training 'works or not', but aims to get beneath the surface and understand who might benefit most from the training, and to uncover those factors that are associated with positive outcomes and

identify areas where the planned activities did not translate into the intended outcomes. In turn these insights will be used to inform recommendations for any future rollout of the training.

2. Evaluation methods

This chapter briefly describes how the evaluation was conducted. It does so by summarising the range of methods used to collect information, and how these data were analysed[1]. It also provides details about who participated in the evaluation, including respondent numbers and rates.

2.1 Data collection

This evaluation comprised the following elements:

- consideration of the records held by NHS Greater Glasgow and Clyde on number of sessions run in each CH(C)P and attendance levels at each of these events;
- questionnaires for completion by all participants before attending the training, at the end of the training, and at three month follow up;
- four follow up depth interviews and four follow up focus groups with a sample of participants, all of whom had previously provided written consent that they could be contacted for evaluation purposes, and who had attended the training in the preceding four to eight months.

The questionnaires[2] were developed by the consultant in order to assess the outcomes and assumptions that have been described in the introductory chapter of this report. Procedures were put in place to collect information from as many participants as possible: achieving a high response rate is important in order to minimise problems of bias and in terms of having confidence that the responses are likely to be representative of the views of participants as a whole. Thus:

- all participants were required to complete a questionnaire prior to attending the training and to bring this along on the day;

[1] Further details about the statistical analyses are provided in the next chapter.

[2] Copies of these are available as an appendix to this report and/or on request from Brenda Friel, Smokefree Services, NHS Greater Glasgow and Clyde.

- the training session itself included ring-fenced time for completing the post-training questionnaire, and so this component of the evaluation was an integral part of the session;
- the follow up questionnaire was sent to all who attended, and procedures were put in place to enable NHS Greater Glasgow and Clyde to issue reminders to those who did not return these.

Furthermore, all participants were asked (via an information sheet) whether they would be willing to be contacted by the consultant in order to be invited to take part in an interview or focus group that would run several months after the training. Those who were willing to be contacted were asked to complete a consent form that was developed for this purpose. This approach was used to allow the researcher to subsequently select individuals from across all ten CH(C)Ps and from the range of the professional groups attending the sessions.

Across the evaluation, measures were taken to ensure that responses would be anonymised, and that participants would understand that this was the case. Assuring participants that their anonymity will be protected is important to encourage open and honest feedback. Thus:

- the pre-training and post-training questionnaires were completed on an anonymous basis;
- although respondents were required to provide their names on the follow up questionnaires they were informed that these details were for office use only(so that non-responders could be 'chased up') and would be removed prior to data entry;
- the consultant assured focus group participants and interviewees that she would not disclose names or details about participating individuals in any reports arising from the evaluation, or indeed in any verbal communications. Furthermore, the consultant explained that she would further protect their anonymity be presenting findings in a manner in which the identity of individuals could not be *inferred.*

Importantly, the use of the mixed methods approach outlined above was intended to provide *breadth* (through administering questionnaires to all participants) and *depth* through detailed exploration of key issues via the focus groups and one-to-one interviews.

2.2 Data coding and analysis

NHS Greater Glasgow and Clyde entered all questionnaire data onto a database and performed analysis of the quantitative data. The outputs from these analyses were sent to the consultant for inclusion in this evaluation.

The interviews and focus groups were conducted by the consultant using a topic guide that had been developed for this purpose. This was structured to obtain views on: the perceived appropriateness of the training in general and on the five-point plan in particular; and whether (and if so how) practice was felt to have changed as a consequence of attending the training; the circumstances that make it more or less likely that participants will apply elements of the five point plan in practice.

The focus groups were conducted in community settings that were chosen with a view to their accessibility for invited participants. These lasted between 40 and 55 minutes.

The one-to-one interviews were conducted by phone: three lasted between 20 and 25 minutes while one lasted just nine minutes.

The focus groups and interviews were audio recorded (with participants' consent) and subsequently transcribed.

Data from the focus groups and interviews were analysed thematically. The analytic approach was informed by Framework[viii], an approach devised for qualitative policy evaluation and used by the National Centre for Social Research. Thus analysis involved summarising data by drawing out the range of views expressed and identifying areas of agreement and divergence of opinion[3].

2.3 Respondent numbers and rates

Over the first year of the programme's implementation (up until June 1st 2010), 231 attended the training. The response rates for the pre- and post-training questionnaires were 98% and 99% respectively. For the questionnaire issued at 3 month follow up, the rate was 70%.

A total of 16 people participated in the depth interviews and focus groups. These participants performed a wide range of professional roles, thereby reflecting the diverse range of those trained. These included: health visitors and staff nurses working in a health visiting team; dental health support workers (one who worked as part of a health visiting team and two who did not); family centre and nursery school staff (managerial and operational), a health improvement practitioner, a health care assistant, and an individual working within the child-minding field. At least one staff member from each of the ten CH(C)Ps took part.

[3] In this report, quotations are followed by the interviewees' /focus group codes. Interviewee codes run from I1 to I4. Similarly each participant in the focus groups have a unique code [Pn] based on their focus group [FG1 to FG4] and the number of participants in each respective group.

3. Findings

In this chapter, findings are presented in order to consider:

- Has the training programme been implemented as intended?
- Has the training led to its intended outcomes, and what are the circumstances associated with it doing so or not?
- Do the underpinning assumptions seem to 'hold true'?

These questions are considered below. More specifically they will be framed in terms of the key outputs and outcomes detailed in the logic model (in Figure 2).

3.1 Has the training programme been implemented as intended?

At the time of the logic model's development and agreement in July 2009 , the intention was that by March 2010, a minimum of two training sessions would run in each of NHS Greater Glasgow and Clyde's ten CH(C)Ps and that in each of these areas a minimum of 16 people would attend.

3.1.1 Did the CH(C)Ps deliver as many training sessions as they intended?

Half the CH(C)Ps succeeded in running at least two sessions by the target date. Four had run one session by then and one had not run any. Two CH(C)Ps had surpassed the milestone running three training sessions by the end of March.

By the 1st June however, all ten CH(C)Ps had run at least two training sessions. (By this date, a total of 27 sessions had been run across NHS Greater Glasgow and Clyde).

3.1.2 Did the CH(C)Ps train as many participants as they had hoped?

The intention had been for a minimum of 16 people to be trained in each CH(C)P by March 2010. Five CH(C)Ps achieved or indeed exceeded this target, some by quite a margin (in one CH(C)P, 29 were trained by this date).

By 1st June, at least 16 people participated in the training in eight of the CH(C)Ps; two areas did not achieve this milestone. On the other hand, some areas trained well over the minimum numbers by this date so that by June 1st; a total of 231 individuals had participated in the training.

The findings in the remainder of this report are based on the feedback obtained from this cohort i.e. those who attended training up to and including the 1st June and who provided feedback via completed questionnaires and/or interviews and focus groups.

3.1.3 Were the participants those who the training programme intended to target?

Prior to the training being rolled out, a number of issues to do with targeting were highlighted. These were that the training should be targeted at those in regular contact with families with children under the age of 5 years, and that SHS messages are more likely to be accepted and acted upon if the message carrier is considered to be a credible and authoritative source. On the basis of these considerations the commissioners drew up a list of those who they suggested should be targeted for training in the first instance. These were health visitors; practice nurses; dental support workers; family support workers; oral health promoters; dental nurses; and 'Parents and Children Together' teams (PACTs).

Participants were asked to indicate their role in the pre-training questionnaire. Their responses show that 46 (approximately 20%) were health visitors. The second commonest participant 'type' was family support worker with 32 (14%) describing their role in this way. Dental support workers and oral health promoters accounted for a further 20 (9%) and 6 (3%) participants respectively. And one respondent described themselves as working in a PACT. Together, these accounted for 47% of participants.

Notably however, a further 17 (8%) worked within a health visiting team, either as a staff nurse or as health visiting support worker. Including these individuals in the count indicates that 55% of participants 'matched' the profile of those who were felt to be the key ones to target in the first instance.

Participants were asked to indicate whether they worked full-time or part-time. This question was underpinned by an assumption that, all things being equal, population health impact is likely to be higher in those circumstances where the professionals are contracted to work more hours. The findings to this item indicate that 147 (65%) worked full-time. Of the remainder, 32 (46%) worked 4 days per week.

Similarly, it was assumed that participants could potentially have a larger population health impact on children under five if they had direct contact with many rather than just a few families with children of this age. Participants were asked to provide a rough estimate of the numbers of families with whom they expected to have direct contact over the next six months[4]. In this respect, 123 (58%) estimated that over the next six months, they were likely to have direct contact with more than 36 such families with a further 21 (10%) estimating that they would have contact with 25-36. At the other end of the spectrum however, 12 (6%) indicated that they had expected to have no direct contact with parents/carers of five year olds over this time period, and a further 14 (7%) indicated that they expected to have contact with between one and six families.

[4]Response options were none, 1-6, 7-12, 13-24, 25-36 and more than 36.

On the basis of the findings, it would seem that: over half of those participating in the training could be considered to 'match' the profile of those initially identified as those whom the training should be targeted in the first instance; and the majority had direct contact with an appreciable number of families with children under the age of five. Conversely, a significant minority of those participating in the training had roles/jobs that did not feature among those that the training was meant to target, and a small minority had extremely limited contact with families of young children.

3.1.4 Were the participants well placed to follow up families?: views in post-training questionnaire

The five-point plan involves follow up action with families. Therefore the effectiveness of the training is premised, in part at least, on the assumption that those trained will be well placed to engage in such follow up activity. Hence, participants were asked (in the post training questionnaire) whether follow up was possible in their role: 81 (36%) responded 'yes, easily', 125 (60%) indicated 'possibly', 7 (3%) said 'no' and 11 (5%) indicated that they ''don't know'.

The fact that only 36% gave an unequivocal 'yes' raises a question as to whether only some (in fact, a minority) of those who attended the training were well placed to carry out the full five point plan.

This raises the question: how plausible was it to assume that those trained would be able to support families in an on-going manner in relation to SHS?

3.2 Did participants 'need' the training?

The training is premised on an assumption that participants will benefit from attending. This presupposes that they would not already have detailed knowledge about SHS and its effects, and/or skills in delivering brief interventions to reduce SHS exposure in the home.

3.2.1 Self-reported confidence before the training

Prior to the training, participants were asked to rate how confident they felt across the various elements or building blocks of the five-point plan promoted by the training. For each of these elements, individuals were asked to indicate their confidence on a Likert-type scale comprising four response options: 'very confident'; 'quite confident', 'not confident' and 'unsure'. Confidence for the elements of the five-point plan are detailed in Box 1.

Box 1: Self-reported confidence for elements in five-point plan: pre-training responses[5]

Describing the constituents of tobacco smoke

Most (n=134, 61%) indicated that they were 'not confident' with just 46 (21%) indicating they were 'quite confident' and 8 (4%) responding that they were 'very confident'.33 (15%) said they were 'unsure'.

Explaining the effects of SHS on children

Again the most common response (n=107, 48%) was 'not confident'. 92 (41%) indicated they were 'quite confident' and just 3 (1%) responded that they were 'very confident'.

Assessing children's exposure to SHS

121 (56%) described themselves as 'not confident', 66 (30%) as 'quite confident' and 7 (3%) as 'very confident'.

Raising the issue of children's exposure to SHS with parents/carers

106 (48%) indicated that they did not feel confident in this respect, compared with 77 (35%) who felt 'quite confident' and 18 (8 %) who felt 'very confident'.

Assessing parents'/carers' readiness to make their home or car smoke free

119 (54%) reported that they were 'not confident' in making this assessment. 67 (30%) indicated that they were 'quite confident' and just 8 (4%) were 'very confident'.

Reducing the risks associated with exposure to SHS in the home/car

117 (53%) indicated that they were 'not confident'. 78 (35%) responded that they were 'quite confident' and 6 (3%) were 'very confident'.

[5] Note percentages have been rounded to the nearest whole number and therefore may not add up to 100%

Helping my clients overcome difficulties in making their home or car smoke free
120 (55%) indicated they were 'not confident', 68 (31%) were 'quite confident' and 5 (2%) were 'very confident'.

Dealing with relapse
139 (63%) responded that they were 'not confident' compared with 51 (23%) who were quite confident and 2 (1%) who were 'very confident'.

The general pattern that emerged before the training was of approximately half the respondents indicating that they were not confident that they had the knowledge and skills that would equip them to deliver the five-point plan i.e. about half the participants felt that they were not confident in their abilities to talk about the dangers of SHS to parents of young children, and they were not confident that they could encourage and support families to make the necessary changes to reduce SHS exposure in the home and car.

The areas associated with least confidence were 'describing the constituents of tobacco smoke' and 'dealing with relapse'.

Against this backdrop, a significant minority reported that they felt 'quite confident' about the knowledge and skills they had to address SHS exposure in the way set out in the five-point plan.

3.2.2 What did participants hope to get out of the training?

The pre-training questionnaire asked participants to explain what they hoped to get out of the training. In the main, their responses simply reinforce the findings above i.e. many highlighted that they wanted to improve their confidence and knowledge in talking about SHS and their skills in tackling it.

A number of notable issues emerged too. First, a sizeable number used the term 'passive smoking' rather than the currently preferred language of SHS. Second, some mentioned that they wanted up-to-date evidence. This might seem to imply that they felt that the evidence base had changed over time. Third, a few commented that they wanted to learn about effective practices and 'how to reduce the impact' of SHS. This suggests an interest in outcomes (e.g. changes in parents' behaviours) rather than just changed activities (e.g. talking to parents more about SHS).

3.2.3 Previous training in motivational interviewing

The five-point plan is rooted in a motivational interviewing framework i.e. it advocates that practitioners adopt a non-judgemental approach and that they facilitate and guide clients rather than directing them, taking into account their receptiveness and readiness to change.

As the five-point plan involves motivational interviewing skills, the pre-training questionnaire also asked whether participants had previously been trained in these techniques. The majority (165, 75%) indicated that they had not with a further 25 (11%) responding that they were 'not sure'.

On the basis of these findings, it would seem that the majority of respondents did not consider that they had the knowledge and skills that the training was seeking to develop prior to attending.

However, it is important to note that many of those attending the training were not those who were initially identified as the target group.

Furthermore, addressing the question – did participants need the training – from just considering their views and confidence levels beforehand may not give the full picture. For example, it may have been the case that participants were not aware of their needs until they had been on the training i.e. they may not have been able to predict whether and how the training might be useful.

3.2.4 Perceived utility of training

Survey findings

The post-training questionnaire included a series of questions to assess how useful participants found the key components of the training, specifically input that is integral to and or necessary to deliver the five point plan i.e. information on constituents of tobacco smoke and the effects of SHS on children; assessing children's exposure to SHS; how to raise the issue of SHS with parents/carers; how to assess parents'/carers' readiness to change; how to overcome roadblocks/barriers to making the home or car smoke free; and how to deal with relapse.

Overwhelmingly, the responses indicated that the training content was considered to be professionally useful: nearly all the respondents rated these key elements of the training as 'very useful' or 'quite useful' in terms of their professional role, with the most common rating by far being 'very useful'. Generally speaking the usefulness of those elements of the training to do with information (i.e. the 'whats') were rated slightly more favourably than those concerning practices (i.e. the 'hows'). A breakdown of responses is provided in Box 2.

Box 2: Breakdown of responses on utility of training elements[6]

Information on constituents of tobacco smoke

183(81%) rated this as 'very useful' and 43(19%) as 'quite useful'. One person (0.4%) rated this as 'not useful'

Information on effects of SHS on children

193(85%) rated this as 'very useful' and 32(14%) as 'quite useful'. Two individuals (1%) indicated that this was 'not useful' and a further one (0.4%) indicated that she did not remember this bit of the training.

Assessing children's exposure to SHS

184(81%) rated this as 'very useful' and 39(17%) as 'quite useful'. Four (2%) indicated that this was 'not useful'.

How to raise the issue of SHS with parents/carers

168(74%) rated this as 'very useful' and 56(25%) as 'quite useful'. Three (1%) indicated that this was 'not useful'

How to assess parents'/carers' readiness to change

149(66%) rated this as 'very useful' and 74(33%) as 'quite useful'. Three (1%) indicated that this was 'not useful' and a further one individual (0.4%) indicated that she was unsure.

How to overcome roadblocks/barriers to making the home or car smoke free

155(68%) rated this as 'very useful' and 70(31%) as 'quite useful'. Two (1%) indicated that this was 'not useful' and a further one individual (0.4%) indicated that she was unsure.

How to deal with relapse

151(67%) rated this as 'very useful' and 71(31%) as 'quite useful'. Three (1%) indicated that this was 'not useful' and a further one individual (0.4%) indicated that she was unsure.

Thus it would seem from the responses above that the vast majority of the participants felt that they had benefited from the training insofar as the content of the training was generally considered to be *useful*.

Findings from interviews and focus groups

In the follow up interviews and focus groups, participants were asked to reflect on whether they felt that they needed the training.

First, and most commonly, was a view that the training was professionally valuable. In the main the reported benefits were in relation to learning about or learning more about SHS, and being reminded about SHS and its dangers. The issue of increased knowledge is picked up in more detail later in the report.

[6]Note percentages have been rounded to the nearest whole number and therefore may not add up to 100%

In contrast to the overwhelming support for the view that the training was beneficial, a small minority expressed contrary views. For some the training was considered as not being professionally relevant: these individuals felt that it was not their job, indeed some believed that it would be *inappropriate*, to ask families about their smoking.

One individual (a health visitor) felt that the training was too basic for her needs: she explained that talking to families about smoking and SHS was already a routine part of her practice, and the cycle of change theory on which the training is based was something that she had done many times before.

These preliminary findings highlight the importance of considering not simply whether the training is 'good' or not, but crucially, who is most likely to benefit from it and in what ways. More specifically, the key questions that will be addressed in the remainders of this chapter concern the effectiveness of the training in achieving what it set out to do.

3.3 Did the training achieve its intended short term outcomes?

The logic model presented earlier (in figure 2) highlights key changes that the training was expected to effect. This section of the report considers the evaluation's findings in relation to each of these outcomes. It does so by presenting and reflecting on the feedback that was obtained via the questionnaires and from the focus groups and interviews.

Note on the reporting of statistical analyses and significance

In the case of the quantitative data (from the questionnaires), change is assessed using statistical tests of significance: Levene's test for Equality of Variances and t-tests (independent samples) for Equality of Means. Such tests determine: whether or not there is a difference in the patterning or spread of responses (Levene's test) and the 'average response' at different points in time (i.e. pre- and post- training, and at three month follow-up); whether any such response change is in the expected direction; and whether the magnitude of any difference is greater than one might explain in terms of 'chance' alone.

In the interests of readability, details of analyses are not provided in this report. Rather, in those instances where change is assessed via comparison of responses at two different points in time, significant difference is simply reported as being present or absent: unless stated otherwise, the p-value for significance is .000.

Details of the analyses (including means, standard deviations and degrees of freedom) can be provided on request by NHS Greater Glasgow and Clyde[7].

3.3.1 Some context setting: reactions to the training

First, to help contextualise the findings relevant to the training's intended outcomes, and on the assumption that the training was more likely to be effective in achieving these if the content and delivery was felt to be appropriate, participants' reactions to the training were obtained.

[7]All statistical tests of significance were conducted by Margaret McGranachan, NHS Greater Glasgow and Clyde who can provide further details on these tests on request.

Survey findings

Respondents' feedback indicates that the overwhelming majority held a very favourable view at the end of the training. Thus they felt that the pace of the training, the level of information provided, and the trainers' knowledge of the topic were all appropriate. Further details of their responses (on Likert-type scales) are provided in Boxes3and 4.

Box 3: Ratings on the content of the training (post training questionnaire)[8]

Pace of the training

Pace of training was rated as 'just right' by 207 (90%). 14 (6%) found it a 'bit too slow' and 8 (4%) found it too fast.

Amount of information on constituents of tobacco smoke

214 (93%) felt that this was 'about right'. Eight (4%) found it 'a bit too much to take in' and 6 (3%) found it too basic.

Amount of information on effects of SHS on children

207 (91%) found the level of this information 'about right'. 17 (7%) felt that this information was 'a bit too basic', 'far too basic' or that they 'didn't learn anything new' whereas 3 (1%) felt that there was 'a bit too much to take in'.

Amount of information on the five-point plan

219 (97%) found this 'about right'. Four (2%) found the level of information 'too much to take in' whereas 2(1%) felt the information was 'far too basic' or that they 'didn't learn anything new'.

The materials used

The ***presentations*** were rated as 'very useful' by 157 (69%) and 'quite useful' by 70 (31%).

The ***hand-outs*** were rated as 'very useful' by 181 (79%) and 'quite useful' by 47 (21%).

The ***case studies*** were rated as 'very useful' by 143 (63%) and 'quite useful' by 77 (34%). Only 6 (3%) rated them as 'not useful'.

The ***role play*** was rated as 'very useful' by 120 (54%) and 'quite useful' by 81 (37%). 15 (7%) felt that this approach was 'not useful' and a further 5 (2%) responded 'I don't remember this bit of the training'

Box 4: Ratings on the trainers' expertise (post training questionnaire)[9]

The ***trainers' knowledge about SHS*** was considered to be 'generally very good' by 191 (84%) and 'generally quite good' by a further 35 (15%). A scoring of 'pretty average' was given by 2 (1%).

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[8]Note percentages have been to the nearest whole number and therefore may not add up to 100%
[9]Note percentages have been to the nearest whole number and therefore may not add up to 100%

The ***trainers' ability to lead the group through the five point plan*** was rated as 'generally very good' by 187 (82%) and 'generally quite good' by 39 (17%). Two (1%) provided a rating of 'pretty average'.

The ***trainers' ability to answer questions*** was rated as 'generally very good' by 184 (81%) and 'generally quite good' by a further 41 (18%). A rating of 'pretty average' was given by 3 (1%).

No participants provided a rating of 'generally quite poor' or 'generally very poor' to any of these (three) measures of trainers' expertise.

Findings from interviews and focus groups

Overwhelmingly the training was viewed positively. Terms such as 'useful', 'good' or 'very good' were used to describe it. One however (a health visitor) felt the training was a bit too basic, conveying little that she did not already know.

3.3.2 Did the training lead to increased knowledge of risks of SHS among participants?

Survey findings

Increased knowledge was assessed via comparison of respondents' responses to two questions that were posed prior to the training and at the close of the session i.e. via the pre- and the post-training questionnaires. These assessed self-rated confidence in describing the constituents of tobacco smoke and in explaining the effects SHS has on children.

For both items there was a significant difference: at the end of the training, participants' confidence was higher in terms of describing the toxicity of SHS and explaining the risks this poses for children's health

Findings from interviews and focus groups

Many who took part in the follow up focus groups and interviews reiterated that they benefited from the training through developing a better understanding of the risks of SHS: when asked what 'stood out' for them from the training, many commented that they had learned more about SHS risks to health, and in so doing talked of their increased knowledge about the toxicity of SHS and how long it resides in clothes and the atmosphere. The following extract from a focus group is illustrative of this:

> *What stood out for you from training? (JG)*
>
> *Information on the chemicals in second hand smoke (P1)*
>
> *I was really shocked actually how many chemicals was there and how much damage that it does to people who don't smoke and who are around people who are smoking. I didn't realise how bad it was (P2)*

It was surprising to hear how other people's smoking can affect non-smokers (P4)

Just the fact that it can be on your clothes. That was quite surprising (P3)

And on your breath even for a length of time (P4)

I didn't think that I realised that if like a smoker's had a cigarette how long the chemicals are still on them and for how long afterwards (P3) [FG1]

While a small minority found the information that they received quite a revelation (e.g. an 'eye opener') insofar as previously they had not known about, or considered, the effects of SHS, far more commonly was a sense that the increased knowledge was not so much transformational, but rather provided some additional detail that was viewed as interesting and in some cases, valuable:

I went along to see if there was anything I didn't know. I know that sounds awful like I'm trying to be a smart arse and I'm no' but. I know the common sense things – don't smoke in the same room you know and I knew that smoke lingered on your clothes but I didn't know how long it lingered or in a confined space even with an open window so that was quite interesting to find out so it was more information. I knew the basics. Basic common sense information but the new extra bits was quite interesting.

[FG1, P1].

Yes I suppose seeing some of the statistical evidence was helpful. For me something I hadn't really considered before was second hand smoking in cars. It wasn't something I had really discussed with parents before. That was quite interesting. It kinda stood out. [FG3, P2]

Those who talked about gaining the most in terms of knowledge about SHS and its effects were generally in jobs which did not routinely address parental smoking e.g. individuals with a specific role in oral health, childcare, nursery school provision, child-minding etc. As such, they learned more because they knew less at the outset.

I think that the training, with me not being a nurse, it was maybe more relevant for myself. I found it quite interesting because obviously I didn't realise exactly how bad it (SHS) was. And I know it's not good and I know they have problem, that it can cause problems, but to have it actually spelled out was actually good for me. So you know, I did find it useful. And I can see what you're saying, for you as a health visitor it probably was too basic. I think that was a general comment that was made at the training. [FG3, P1]

3.3.3. Did the training increase knowledge of effective ways to protect children from effects of SHS in the car and home?

Survey findings

In the pre- training questionnaires and then again in the post-training one, participants were asked to indicate their level of confidence in 'knowing ways to effectively reduce the risks associated with exposure to SHS in the home/car'. In the post-training questionnaire, 95 (42%) described themselves as 'very confident' and 126 (56%) as 'quite confident'. This represented a significant increase in self-reported confidence on this item at these two points in time.

Restricting smoking to one room in the home as an effective way to reduce exposure?

The training is premised on the assumption that in those cases where it is not realistic to eliminate (all) exposure to SHS in the home/car, it is desirable to limit smoking to one room and to wind down car windows. The underlying assumption is that such measures lead to an increased likelihood of individuals *subsequently* making their homes and cars (totally) smoke free.

In view of the fact that the training is predicated on the notion that it's preferable to restrict exposure in these ways, it was notable that after the training the majority (n=154; 68%) 'disagreed' or 'strongly disagreed' with the statement 'restricting smoking to one room in the house protects children from the effects of SHS'.

That is not to say that these participants were wrong: in the training, it is emphasised that these measures are in themselves *ineffective* in terms of actually protecting children from the effects of SHS.

Notably however, in the post-training questionnaire 46(20%) 'strongly agreed' or 'agreed' and 26 (12%) 'neither agreed or disagreed' that 'restricting smoking to one room house protects children from the effects of SHS'. This suggests some element of confusion remained about whether restricting smoking to one room is an effective way to reduce children's exposure to SHS.

Similarly a few participants indicated a lack of clarity in their written comments after the training. For example:

I felt that there was a bit of confusion about parents smoking in a separate room from the child and smoking outside and the effects of this on the child. Did not feel that trainers properly explained initially that smoking in a different room to the child is still considered as second hand smoking.

Findings from interviews and focus groups

From the focus groups and interviews, there was plenty of evidence that the individuals involved 'took away' from the training the dangers of SHS. As a consequence of this enhanced awareness, they understood that the most effective way to protect children was to *eliminate* smoking in the home and car.

Similarly, there was evidence that participants left the training with an understanding that children could be protected if smokers smoked outside rather than indoors or in the car. That is not to say that this was *new* knowledge for many of them. (Indeed several commented that the families with whom they worked also understood that they should not be smoking near their babies.) Therefore, the training seemed to remind and reinforce participants' prior awareness of the importance of not smoking near children.

However, beyond this, there was also some confusion about exactly what constituted an effective harm reduction measure. This expansive account (from a health visitor) is illustrative of this point:

> *I think that as health visitors prescribe nicotine replacement and things like that, we do have a good grounding in smoking and the effects of smoking on children and adults and so on reflection it (the training) is a bit basic. I think I was looking for a bit more information and also more, I'd hoped for more in a risk assessment sort of way. I'd been hoping I'd be able to say to parents like parents who were smoking in another room, so say they only smoke in the kitchen with the window open and they don't smoke in the main living room and things like this, what happens if the clothes that they are wearing – how does that affect the baby. Should we maybe be telling parents to put on something to smoke in, perhaps like a top they just smoke in, and they take that off. But that wasn't addressed. Because I suppose they haven't done the research to say that reduces the nicotine on your clothes or the amount the child inhales or things like that, or contact with the child's skin. They weren't able to answer things like that. So that kind of information I would have kinda liked – to be able to tell people, tell parents, knowledgably, well that's better than smoking all round the house.* [FG3, P2]

3.3.4.Did the training increase participants' awareness of opportunities to talk about SHS?

Survey findings

Responses to the survey issued at the end of training indicated statistically significant increases in participants' expressed intention to talk to parents/carers about SHS across the full range of scenarios detailed in the questionnaire:

- when I know (for certain) that the parent/carer with whom I have contact smokes
- when children and/or their belongings smell of smoke

- when I know for certain that a child is being exposed to second hand smoke at home
- when I know for certain that a child is being exposed to second hand smoke in the car
- when I suspect a child is being exposed to second hand smoke at home
- when I suspect a child is being exposed to second hand smoke in their car
- when the child is experiencing health conditions known to be associated with exposure second hand smoke.

Such changes are consistent with (and thereby support) the conclusion that the training increased awareness of opportunities to talk about SHS.

Findings from interviews and focus groups

Interviewees and focus group participants identified the training as opening up some possibilities for raising the issue of SHS. First, some talked of the training increasing their awareness that they should raise the issue, and in a sense serving as a reminder that they should do so.

> *I think it's always good to refresh yourself and put it to the forefront of your mind, yeah, and how to bring it up with families you know if it was going to be an issue…I am not sure that we learned anything about bringing it up. More em, just more awareness that we should bring it up if there a problem, yeah.* [I3]

Others talked of the training 'giving them permission' to raise the issue even if they were not going to pursue this with families:

> *Training helped me to broach the subject with families. … I felt that it gave me a way in to bring it up … the important thing was that the training gave you permission to bring the subject up, that if the family's not interested, you just leave them with the information, you didn't need to pursue it. You just leave them with the information and back off and that was really helpful for me. To know that I could just bring it up and not push.* [FG4, P4]

The quote above touches on the next theme: the leaflet *Keep your family safe from second hand smoke (the 'teddy bear leaflet')* that was produced by NHS Greater Glasgow and Clyde was identified time and time again as providing participants with an opening to talk to families about SHS. Notably this was seen as a soft and non threatening way to raise the subject of SHS with families:

> *I liked the idea of just having a leaflet, being able to bring the subject up and say just have a wee look at it, I'll maybe speak to you next time I'm out or something like that, rather than going in too heavy and just being able to leave the information and maybe broaching it the next time.* [FG4, P2]

In this way, the leaflet then was described as actually *creating* the opportunity to raise the topic:

It's easy to broach it because it is easy to say, oh, I've got this leaflet as well, does anyone smoke in the house? I mean I know already that they smoke so it's easy really to bring it up because you are going through this list of things that needs to be done so it's not as if you're bringing it up and offending people. It's just something you have to do (P1)

Having the leaflet makes it easier (P2)

It does (P1)

Because it's not me being nosy. It's a legitimate reason that I'm asking you about this (P2)

Yeah, because I've got all the leaflets on my knee – and here's the safety one, and then we go through that, and here's the second hand smoke one, and I do say - does anyone smoke in the house and that's when they'll say –oh, I smoke outside. And I'll say - oh that's very good. Or they maybe say, I smoke in the kitchen and that's maybe where I say -is it possible to take it outside?' (P1) [FG3]

For some, giving out the leaflet was not just *an* opportunity to raise the topic; it was the *only* one that they felt was appropriate within their role:

I am more than happy to give out the leaflet. I would be happy to read out the leaflet. But I see my role as directing to someone else. [FG2, P1]

Finally, one individual who worked in a nursery school setting described how, following the training, her team considered what opportunities were available for them to address the issue in a manner that was appropriate to the context in which they worked, and developed materials that were intended to prompt children and their parents to consider the environmental impact of cigarette smoking:

We tackle it a bit different. Although we give out the leaflets and things and made our parents aware that our staff were on the training course and what it entailed, we also implemented it as part of our curriculum for excellence with our carbon footprint so we went down the way of reducing it that way… back door way rather than face to face. [FG4, P1]

3.3.5. Did the training increase confidence in talking about the risks of SHS to families/carers?

Survey findings

As already reported above (see 3.3.2), there was some evidence of respondents reporting feeling more confident in explaining the effects of SHS after the training than they did before. Comparison of responses in the pre- and the post-training questionnaires indicated a significant increase in confidence in describing the toxicity of SHS and explaining the risks this poses for children's health.

Findings from interviews and focus groups

In the interviews and focus groups, most seemed to feel that the knowledge gained in the training equipped them with an ability to talk about SHS risks. Furthermore, a few were explicit that their confidence improved *as a result of* attending the training:

> *I think I have more confidence after the training. Having mair confidence, learning, makes you have the confidence to speak to more people rather than just saying it from what you think you know.* [FG1, P2]
>
> *Having gone through the training, it gave me the confidence to feel that I had learned more on the training so that I could then go and speak to the families.* [FG4, P4]
>
> *I think the training's great ... It's certainly not at the forefront of my mind and I probably don't speak about it as much as I should but it's definitely in my mind, I am definitely more confident to speak about it.* [FG4, P3]

This increased confidence did not simply stem from the training per se: there was evidence that the leaflet served as an aide memoire or source of back-up information, and in this way, could make some individuals feel more confident to talk about SHS. For example, one practitioner talked about using it '*when you find it hard to speak to someone about it'*, going on to say *'I actually find it useful cos it reminds me of some things as well.'* [FG1, P2] Others felt that the leaflet legitimised talking about SHS, and this made them feel more comfortable about doing so.

3.3.6 Did the training improve skills in carrying out brief interventions to reduce SHS exposure?

Survey findings

Confidence in practising the key elements of the five point plan were assessed before and after the training. In this way, confidence was intended to serve as a *proxy* measure for skills development – an outcome that could not be objectively assessed within this evaluation.

Comparison of responses prior to and at the end of the training indicated significant increases in confidence across all the elements of the five point plan. Thus, at the end of the training there was increased confidence in:

- describing the constituents of tobacco smoke (already reported)
- explaining the effects of second hand smoking on children (already reported)
- assessing children's exposure to second hand smoke
- raising the issue of children's exposure to second hand smoke with parents/carers
- assessing parents'/carers' readiness make their home or car smoke free
- knowing ways to effectively reduce the risks associated with exposure to second hand smoke in the home /car
- helping my clients overcome difficulties in making their home or car smoke free
- dealing with relapse (when a client tries to make their home/car smoke free but they are unsuccessful in maintaining this).

All of these changes remained significant at follow up i.e. increased confidence was evident across all items three months after the training when compared with levels before the training.

Despite these significant differences, at follow up, there was evidence of *diminished* confidence when compared with the responses provided at the end of the training in:

- describing the constituents of tobacco smoke ($p<.05$)
- helping my clients overcome difficulties in making their home or car smoke free ($p<.05$)
- dealing with relapse.

In other words, for these three areas the levels of improved confidence that had been indicated immediately after the training failed to be sustained to the same level at follow up. In contrast to this, confidence at follow up did not decrease significantly from that at the end of the training across the majority of the five point plan elements i.e. explaining the effects, assessing children's exposure, raising the issue , assessing parents'/carers' readiness make their home or car smoke free and knowing ways to effectively reduce the risks.

Findings from interviews and focus groups

As a starting point, improved skills in carrying out the 5-point plan were explored by asking participants what they remembered about it. The most common response to this question was nervous laughter and an acknowledgement that they could not recall what was involved. For those few who offered a description of what the plan entailed, there seemed to be some confusion/blurring between the elements of the five-point plan and those of a motivational cycle of change. For example:

It's where you are just broaching the subject, going on to the next stage, what are you gonna do next, moving on through the whole cycle of how do we get you to change what you're going to do, and eventually trying to get them to stop way down the line. [FG3, P1]

You don't necessarily move on. You can come in and out at different stages. You can come in at a level, you don't necessarily move on. I'm not expressing myself very well. You might stick at a level or you might drop back so it's not a step by step process. And the different stages were of not being interested at all, interested in talking about it but not ready to change. [FG4, P4]

While participants experienced difficulties in recollecting the elements of the five-point plan, many seemed to have absorbed some key points from the motivational cycle of change and the implications for conducting a brief intervention:

I think as nurses we are very good at saying you need to do this this and this whereas it (the training) was very much about guiding the person, but very much letting them lead as to what solutions they had. (P2)

If they make the decision for themselves, if they think they are making the decision for themselves they are more likely to do it. I think it was maybe something like that. (P1) [FG3]

Participants in the interviews and focus groups were not always asked directly whether they felt their skills had improved or not (the issue of skills change was addressed by asking about practices, and the findings in relation to these are picked up later in the report). Some insights were provided on this issue, and these are reported here.

Most participants volunteered that as a consequence of the training they felt better equipped to talk to families about SHS:

I think learning about the constituents of smoke because in the past I probably said, don't smoke; it's bad and didn't go any further. Everyone knows smoking's not good but then to be able to explain why it was bad, what effects it would have. [FG4, P3]

This sense of improved skills in talking about SHS often translated into feeling able to *respond* to families if they raised the topic of smoking.

Furthermore, some talked of feeling more skilled in (proactively) raising the topic as the following comment reveals:

Training helped me to broach the subject with families. Having gone through the training, it *gave me the confidence to feel that I had learned more on the training so that I could then go and speak to the families. I felt that it gave me a way in to bring it up … the important thing was that the training gave you permission to bring the subject up, that if the family's not interested, you just leave them with the information,*

you didn't need to pursue it. You just leave them with the information and back off and that was really helpful for me. To know that I could just bring it up and not push.'

[FG4, P4]

Strikingly however the latter two quotes were both provided by health visitors, an issue that gets picked up later in this report in relation to those professional groups who were most likely to be proactive in raising SHS with families *in practice*.

Similarly, those who had a role in health visiting or in some cases, those who worked as part of a health visiting team, also talked in ways that implied that they were more likely or able to ask about exposure to SHS and thereby assess whether children were exposed. From this, an improvement in assessment skills might be *inferred*.

While there was some evidence therefore that might suggest improved skills in raising the topic and assessing exposure, there was no evidence pointing to improved skills across the other elements of the five-point plan. Furthermore, there was even evidence of the training being *ineffective* in developing skills across these remaining three stages, or at least of any skills being sustained at the point of these interviews and focus groups.

So do you feel that you have a role in relation to the step – taking action according to readiness to change? (JG)

That's where my confidence plummets. I really don't know that I would have the confidence to help someone through that. I can give them the information but if someone turned round and said – right, I 'm gonna completely change – I don't know what I would do from there. [FG2, P2]

Similarly, in the one instance where participants were asked if the training helped them think through how they might jointly develop an action plan, the two individuals involved responded with an unequivocal 'no'.

3.4 Did the training achieve its intended medium term outcomes?

The intended outcome of the training was for changed practices: through practitioners changing what they were doing (by conducting brief interventions in line with the five-point plan), it was envisaged that the health risks of SHS would be raised with more parents/carers and (due to the follow up step in the plan) raised more *often* with them too.

3.4.1 Did the training result in increased usage of brief interventions?

Findings from survey

In the follow up questionnaires, participants were asked to indicate whether, and if so to estimate roughly how many times, they had carried out a range of actions to address SHS. In addition, questions were posed in the follow up questionnaire to assess whether or not participants felt that their behaviour had *changed* since attending the training, and if so, the extent of this. Findings in relation to both sets of questions are summarised below and also detailed in tables 1 and 2.

In terms of the reported frequency of actions, there are a number of noteworthy issues:

- the majority of respondents indicated that since the training, they had engaged in actions intended to address children's exposure to SHS on at least one occasion
- the most common action was giving out the leaflet
- the least common actions were identifying obstacles to reducing exposure in the car, and following up parents/carers by asking them how they are getting on in restricting exposure both in the home and in the car
- there was a high percentage of participants indicating that since the training they had never engaged in the specified actions.

Turning now to reported changes in the frequency of specified actions, key findings include:

- the majority of respondents reported an increase in each of the specified practice, but these increases were only modest i.e. across all items, respondents most common response was 'I do this a bit more now' as opposed to 'I do this far more now'
- a high percentage reported that their practice had *not* changed, particularly in relation to following up parents/carers and identifying obstacles to reducing exposure in the car.

Table 1: Reported frequency of specified actions to tackle SHS: data from follow up questionnaires

	Never	1-3 times	4-6 times	7 times or more
I have given parents/carers the NHS Greater Glasgow and Clyde leaflet 'Keeping your family safe from second hand smoke'	27%	32%	14%	27%
I have **asked** parents/carers 'what do they know about second hand smoking and children?'	31%	31%	14%	24%
I have talked of the **dangers** of children's exposure to second hand smoke in the home	19%	33%	16%	31%
I have talked of the **dangers** of children's exposure to second hand smoke in the car	32%	30%	15%	22%
I have **discussed with parents/carers** their **readiness** to reduce children's exposure to second hand smoke in the home	31%	31%	13%	25%
I have **discussed with parents/carers** their **readiness to reduce** children's exposure to second hand smoke in the car	42%	28%	10%	20%
I have suggested **ways to reduce** children's exposure to second hand smoke in the home	23%	33%	13%	31%
I have suggested **ways to reduce** children's exposure to second hand smoke in the car	38%	28%	12%	22%
I have identified with parents/carers their **particular roadblocks/obstacles** to reducing children's exposure to second hand smoke in the home	39%	27%	14%	20%
I have identified with parents/carers their **particular roadblocks/obstacles** to reducing children's exposure to second hand smoke in the car	51%	23%	12%	15%
I have **followed up** parents/carers by asking them how they are getting on in reducing children's exposure to second hand smoke in the home	46%	22%	11%	21%
I have **followed up** parents/carers by asking them how they are getting on in reducing children's exposure to second hand smoke in the car	57%	19%	9%	15%

Table 2: Reported changes in practice to tackle SHS: data from follow up questionnaires

	I do this **far more** now	I do this **a bit more** now	There's been **no change** in what I do	I do this **a bit less** now	I do this **a lot less** now
I have given parents/carers the NHS Greater Glasgow and Clyde leaflet 'Keeping your family safe from second hand smoke'	36%	43%	20%	1%	0%
I have **asked** parents/carers 'what do they know about second hand smoking and children?'	26%	47%	24%	1%	1%
I have talked of the **dangers** of children's exposure to second hand smoke in the home	30%	43%	25%	1%	1%
I have talked of the **dangers** of children's exposure to second hand smoke in the car	26%	45%	27%	2%	1%
I have **discussed with parents/carers** their **readiness** to reduce children's exposure to second hand smoke in the home	20%	47%	30%	1%	1%
I have **discussed with parents/carers** their **readiness to reduce** children's exposure to second hand smoke in the car	18%	44%	36%	1%	1%
I have suggested **ways to reduce** children's exposure to second hand smoke in the home	29%	45%	24%	1%	1%
I have suggested **ways to reduce** children's exposure to second hand smoke in the car	24%	44%	30%	1%	1%
I have identified with parents/carers their **particular roadblocks/obstacles** to reducing children's exposure to second hand smoke in the home	20%	45%	33%	1%	1%
I have identified with parents/carers their **particular roadblocks/obstacles** to reducing children's exposure to second hand smoke in the car	18%	41%	39%	1%	1%
I have **followed up** parents/carers by asking them how they are getting on in reducing children's exposure to second hand smoke in the home	16%	46%	36%	1%	1%
I have **followed up** parents/carers by asking them how they are getting on in reducing children's exposure to second hand smoke in the car	14%	42%	41%	1%	1%

The findings reported provide a 'mixed picture' insofar as some participants reported that they had engaged in practices to tackle SHS and that these represented an increase, whereas others indicated that they did not engage in practices to address SHS and/or that the frequency with which they engaged in these practices had not changed since the training.

This raises the question: do we know whether some 'types' of participants were more likely to practise the behaviours on a more frequent basis, and/or to increase the level of their activity as a consequence of attending the training? More specifically, in view of discussions about targeting that took place prior to the training being rolled out, the data were broken down and analysed to identify whether better outcomes were evident in some professional groupings. As it had been suggested at the outset that those in a health visiting role (including staff nurses) might be best placed to effect reductions in children's exposure to SHS in the home (due to factors such as credibility, role appropriateness, and potential for following up families), cross tabulations (i.e. 'cross tabs') were performed. These compared responses provided by health visitors, staff nurses and others who described themselves as working as part of a health visiting team (n=55, 35%) with those provided by all other respondents (n=103, 65%).

These analyses (using Chi Square) indicated that health visiting team staff was more likely (p=.000) to:

- ask parents what they know about SHS
- talk about the dangers of SHS in the home and in the car
- discuss parents/carers readiness to change
- suggest ways to reduce children's exposure in the home and in the car
- identify obstacles to reducing exposure in the home and the car
- follow up parents/carers in the home and car.

In addition, although less dramatically, health visiting team staff were more likely (p=.002) to give parents/carers the leaflet than were the remainder of the respondents[10].

[10]Analyses were also conducted to compare level of reported changes for those in a health visiting role against the remainder of respondents. These findings largely mirror those reported above with better outcomes being associated with those performing a health visiting role. However, for statistical reasons (more than 25% of cells having an expected count less than 5) these findings, although mostly having p-values of .000 are not reported here as they may not be robust.

Findings from interviews and focus groups

The general story that emerged was of participants feeling that the training had led to an increased awareness of SHS and associated health risks, and that this in turn primed them to respond:

> *Before I would never have thought about it (SHS) whereas now I wouldn't hesitate if I thought it was the right thing to do.* [FG4, P2]

> *I think I maybe spend a wee bit more time talking to families .... I think I maybe give it a wee bit more priority since being on the training.* [FG3, P2]

What they actually did in practice however was very much determined by their professional roles: time and time again, participants described how they applied their enhanced knowledge in ways that felt appropriate to their jobs. For example:

> *It's not really my job to question people on their smoking habit…I think it's more the health visitors and the staff nurses that would be raising issues like that. I mean I'm more or less just going out to do what I've been asked to do and no anything else.* [I2]

Thus, while virtually all participants were quite positive about *responding* to families who themselves raised the issue of cutting back on smoking, many of those who did not work as part of a health visiting team expressed a reticence and indeed reluctance to raise the topic in a *proactive* manner:

> *I think maybe if someone said that they want to give up you could maybe follow on but just now I feel I wouldn't want to initiate the conversation?* [FG1, P4]

In particular, many of the participants felt that their role was not conducive to tackling SHS in a *comprehensive* manner:

> *I'll not shy away from broaching the subject which I think I might have disregarded before I went on the training but I'm not going in with the agenda can I fit in my remit and – and yes I have been in homes where I've noticed an ashtray and to be honest, by the time I've got to the end of what I was discussing, I didn't feel it was particularly appropriate to continue. ..... I think because families we are going into regularly are quite hard to engage with services and given that I am only going in on a one-off situation most of the time, I perhaps don't want to alienate them. You know obviously smoking's a contentious subject (laughs) and maybe I feel that perhaps my role is, although I am going into houses on a daily basis, it's maybe not the best role to get the best result from that. I think perhaps people like health visitors who have more contact with families can build up a much better rapport. I mean bear in mind, I have to make an impression on that one occasion. Erm maybe we're not best suited, our role's not best suited to actually be tackling that as well.* [FG2, P1]

As a consequence many talked of just practising *elements* of the five-point plan. Typically, the elements involved were around awareness raising or explaining the effects of SHS to families, and/or giving out the leaflets.

> *I would never have raised it before I had gone on the training, would never have thought of raising it so it's been really good in that respect. It's made me more aware of it and bring it into my attitude and made me aware that I should be doing it. I have spoken to people since doing the training.* [FG4, P2]

> *I would have raised it at the trigger points say there are definite times that I can bring up the subject of smoking in general. I maybe wouldn't have pushed it as much. It would probably have just been do you smoke, wouldn't have pushed it so much as what's the exposure of your child to that. And the training definitely gave me more confidence to just take it a step further with that really.* [FG4, P4]

A smaller number were also able to give examples of moving beyond simply assessing exposure and explaining the risks, and suggesting ways to reduce children's exposure to SHS (and third hand smoke) in the home e.g. by smoking outside, changing out of the clothes that have been worn while smoking, and washing hands after smoking[11]. At times, knowledge that the child was asthmatic served as a trigger for bringing up the topic. Notably the whole issue of SHS in the car was largely forgotten.

There were also several examples of participants signposting families to smoking cessation services as the training had made them more aware of these opportunities. Interestingly though, a few of these seemed to be confused about the take home message of the training, and conflated the exposure restriction message with a smoking cessation one:

> *I think I've almost forgotten about saying about restricting. I think I've actually almost forgotten about the fact if they still are smoking to make them aware of the changes that they can make in the home.* [FG2, P1]

A small minority of participants talked of supporting families in the comprehensive manner characterised within the five-point plan. Thus, there were indeed some accounts that suggested that some practitioners had discussions with families that did not end at discussing the steps that might be taken to restrict children's exposure to SHS (i.e. developing an action plan), but where the practitioners had the potential to conduct a follow up with the family. For example:

> *I mean one girl, I went in, it was like a bowl of pot pourri but it was cigarette ends and ash on the table, and I was oh no, I am going to be stinking when I come out of here so I spoke to her about the smoking, you know the baby was only 6 weeks old, how dangerous it was for the baby and everything. And I said to her - if you can smoke, at least in another room away from the baby or outside. And she was – aw, are you gonna come back and tell ma mam and sister that they can't smoke in the house? And I said - no, but I'll leave you leaflets and you can give them. But this is, she's only a young girl*

[11] These latter two practices (to reduce exposure to third hand smoke) are not actually discussed or promoted in the training however.

> *but (I said) - this is your house, this is an opportunity for you to be a boss in your house (and say), look, this is the rules. And she was – I'll try, I'll see. And when I went back she went – see see, nae ashtray, ye cannae gie me intae trouble (laughs).*
> [FG3, P2]

Provision of accounts where participants were able to evidence that they had made an impact were very unusual. In the main, those participants who had delivered elements of the five-point plan but who had not had opportunities to see the families again, were not able to say whether or not they had been effective or not. In fact, several were quite pessimistic about the likelihood of them having changed families' behaviour because they felt that they were not taken very seriously and/or because they were unable to engage with families in an ongoing/sustained manner. For example:

> *I'm not really going to get an outcome and I'm not going to make an appointment to come back and see them about that because that's not my role.* [FG2, P1]

There was acknowledgement that certain practitioners are not only better placed to tackle SHS as families will be amenable to discussing the issue with them and receptive to their advice, but also because they are likely to be more *effective* as they have the opportunity to develop good relationships with the families, and to provide sustained (follow up) support:

> *It's not something that you can just rush in and say, that you maybe need to have a bit of a relationship with them and go at it tactfully. I don't think it's just something that you can suddenly say that they shouldn't be doing.* [I3]

> *I think because families we are going into regularly are quite hard to engage with services and given that I am only going in on a one-off situation most of the time, I don't want to alienate them. You know obviously smoking's a contentious subject (laughs) and it's maybe not the best role to get the best result from that. I think perhaps people like health visitors who have more contact with families can build up a much better rapport. I mean bear in mind, I have to make an impression on that one occasion.* [FG2, P2]

3.4.2 What factors influenced participants' decisions to tackle SHS?

Findings from survey

From the follow up questionnaires it was very evident that the majority of respondents felt that they 'knew enough' to address SHS with families/carers: only 8 (5%) agreed or strongly agreed with the statement 'I don't think I know enough to address the SHS issue with families/carers'. Similarly, just 9 (6%) agreed or strongly agreed with the statement that 'I don't have the time to talk to families about SHS in the home'. Thus, neither lack of time nor lack of knowledge emerged as common barriers to raising the topic of SHS with families.

Slightly higher numbers/percentages however agreed or strongly agreed with the statements that 'It would be inappropriate to raise the issue of SHS with families' (n=21, 13%) and that 'I am afraid that talking to families about SHS in the home may damage my relationship with them' (n=24, 15%).

While these issues were not felt to be obstacles by the majority, some did however provide written comments in their questionnaire on exactly these issues. Thus, some commented that the nature of their role or indeed the amount of ground that they had to cover when engaging with families limited their opportunities to tackle SHS, or meant that SHS was not a priority for them as they interacted with families. For example when asked if they experienced any barriers in their practice, comments included:

> *I do not think that it is my place to tell parents/carers whether they can smoke or not. It should be up to the family doctor or health visitor to consult them as coming from us (nursery nurses) it could seem insulting or the parents may feel that it has nothing to do with us.*

> *My priority is to get compliance of parents to carry out programmes with their children to promote their development – second hand smoke is secondary/time constraints*

Others highlighted family factors such as defensiveness and/or their failure to acknowledge SHS as a risk. For example:

> *As we are a non-judgemental service, it would be inappropriate for me to mention second hand smoke and its issues when first meeting families. I feel that this would put up a barrier and we would not be welcomed into the home.*

> *When speaking to parents/carers their mother has said 'I smoke around all my kids and never done them any damage.*

Finally, others cited particular vulnerabilities or inequalities experienced by some families that in themselves constituted barriers e.g. language, learning disabilities, and family stress.

Findings from interviews and focus groups

The accounts provided in the focus groups and interviews provided a more detailed (and indeed nuanced) picture to the one suggested by the survey data: many participants expressed views about whether they felt it was appropriate within their role to raise the issue of SHS with families, while others talked about having many opportunities to do so, including opportunities to engage in a sustained manner.

That was not the full story however in terms of what factors influenced their decisions to raise the topic with families, with several pointing to the fact that many of the families with whom they work are extremely vulnerable, experiencing multiple needs including, for example, mental health problems, addictions, child protection issues etc. In view of these

vulnerabilities, many participants (both within and outwith health visiting teams) felt that some families had so much adversity in their lives that SHS was neither one of their priorities nor indeed that of the practitioners supporting them.

In contrast, many of the less vulnerable families were believed to already understand that they should not be smoking near their children. In fact, the majority were believed to be either not smoking at all (a comment made about those in the more affluent areas by one of the health visitors) or not smoking near their children (e.g. in a different room or out on the landing).

3. 5 How might the training be improved?

Findings from survey

The post-training questionnaire asked participants how they thought the training might be improved. Four issues emerged most commonly. First, some wanted more detailed information on SHS and on third hand smoke e.g. more information on length of time that SHS stays in the atmosphere and /or on clothes. Second, there were calls for more input on motivational interviewing and/or on the process of tackling SHS with families, including helping families to overcome obstacles to reducing children's exposure to SHS. Next, some wanted more information on smoking cessation, including details about local cessation services. Finally, and no doubt in view of the high numbers of oral health workers attending, several called for information on how SHS affects children's teeth.

The follow up questionnaire included an open ended question that asked whether there was anything that was missing from the training and that might be improved. A number of notable themes emerged here too.

First, the heterogeneous needs of respondents became apparent. So, some commented that some of the training felt insufficient or rushed (e.g. opportunities for discussion and the input on motivational interviewing) while a more common complaint was that the session was too long and that the content could be condensed (e.g. because '*already aware of motivational interviewing and process/cycle of change*'). As a result then, there was an issue of the training not being pitched at an appropriate level for all. This was explicitly identified as an issue for participating health visitors, for example:

> *Sorry but I felt that it was pitched too low. The information and engagement with families is common practice among health visitors, I appreciate the group was mixed but it didn't need three hours.*

> *Content requires further depth to be informative for the perspective of the health visitor…content provided on the day was very basic.*

Given the fact that a key target group for the training was meant to be health visitors, such concerns about the content of the training are particularly noteworthy. In fact, there was a sense from one respondent that the training failed to appreciate /acknowledge the context in which health visitors work.

Second, and allied to comments about the training being too basic, several highlighted the need for the training to impart better evidence on how to (effectively) reduce the harmful effects of exposure to tobacco. In particular, several raised issues about exposure to third hand smoke including the view that the training failed to address the extent to which

reductions in smoking and/or restricting smoking are protective practices. Illustrative comments included:

> *I feel that there was a bit of confusion about parents smoking in a separate room from the child and smoking outside and the effects of this on the child.*
>
> *The extent to which second hand smoke affects children if (1) a room in the house is used say in the evening only, say the kitchen (2) the effect of second hand smoke on clothes, hands, from breath etc. More specific statistics, effects etc.*
>
> *I thought we could have had more detailed information on topics like how long after the person could cuddle the child or if there were particular things that could be done e.g. hand-washing, teeth-brushing.*

The third set of responses concerned the need for the training to better relate to the 'how' aspects of the issue i.e. how the practitioners might address the issue within the context of their professional roles. So this was not seen to be just a matter of them needing sufficient information. Rather, some identified an outstanding need in relation to effective professional *practices*. So for example, one respondent felt that more was needed *'in regards to the everyday stresses and worries which these families have which in my life can be very chaotic'.* The issue about some respondents feeling that the training did not provide them with enough on motivational interviewing is noteworthy in this respect too i.e. some left the training feeling that they were not well equipped to guide families through a change cycle.

Finally, some commented on the style of the training and how it might be improved. In particular several felt that the training would benefit from being more interactive.

Findings from interviews and focus groups

Although not a training issue, several participants in the focus group suggested that it would be helpful if the leaflet was available in other formats, specifically in different languages and in a simplified form for families with literacy problems or learning disabilities.

4. Reflections and recommendations

The training was delivered to each of the CH(C)Ps, with the overwhelming majority achieving the targeted number of sessions and participants, albeit over a slightly extended time period than initially planned.

This chapter distils key findings from survey data provided by participants, and from insights obtained from interviews and focus groups with a small sample several months after the training.

It considers the implications of these findings for any future roll out of the Roy Castle training programme via CH(C)Ps in the NHS Greater Glasgow and Clyde area.

4. 1 Effectiveness: in what, for whom and over what time period?

This evaluation has indicated that overwhelmingly those who attended the training viewed it extremely positively: the training was considered to be interesting, informative and well-delivered. As a consequence, most felt that attending the training had been a good use of their time.

Furthermore, the training also resulted in striking improvements in self-reported knowledge and confidence in the area of SHS: findings based on a comparison of responses prior to the training with those at the end of the session as well as at follow up, give an extremely positive picture indeed, suggesting that the training had been effective in terms of its key learning outcomes. Thus, participants (as a population) benefited in terms of knowledge gained about the toxicity of SHS, and confidence in not only explaining deleterious effects on children but also in feeling more confident to actually talk to families about how to reduce exposure.

However, prior to the training being rolled out, careful consideration had been given to what the training was intended to achieve in the *longer term*, and those involved in these discussions were in agreement that the aspiration was that those who attended the training would go on and carry out brief interventions, including follow up support, and reduce children's exposure to SHS in the home and car. While the longer term outcomes of reduced exposure were felt to be beyond the scope of this evaluation, it was agreed that more proximal outcomes included increased use of brief interventions i.e. the five-point plan that the training promotes.

Certainly the findings of this evaluation point to the training being effective in terms of imparting some of the information on which the five point plan relies. Thus participants felt more confident in their abilities to *explain* the effects of SHS.

Questionnaire data and the findings from the interviews and focus groups provide some crucial insights into factors associated with the training being more or less effective in achieving its intended outcomes, particularly those that concern usage of the five-point plan in its entirety. In fact the findings can largely be explained in terms of professional role.

A strong recurring theme was that while the majority of participants felt that they, potentially at least, could talk to families about SHS, only some felt well placed to be proactive on the issue and to engage with families in an ongoing/sustained manner. Analyses of the questionnaire data and the findings from the interviews and focus groups indicated that those in a health visiting team were more likely to intervene with families, and indeed to follow them up, than other participants. That is not to say that none of the other participants did more than simply perform an awareness raising/information dissemination role at follow up: rather the issue is that as a general pattern, those in other roles were *less likely* to apply the principles of motivational interviewing and engage in families in a sustained manner. Thus in terms of the likelihood of this training ultimately leading to a reduction in children's exposure to SHS, it would seem that any such changes are likely to be mediated by those participants with a health visiting role.

Notwithstanding this 'health visitor team effect', there was evidence that the training led to positive outcomes in others too as they became more informed about SHS and its effects. Thus, there was evidence of participants more generally feeling better equipped to talk about SHS. For those who did not perform a health visiting role, this meant that they felt more confident and competent in responding to any interest in the topic shown by families.

There was also evidence that many performed the role of advocates or message carriers. Thus there were many instances of participants (holding diverse roles) bringing the topic to the attention of families. The leaflet produced by NHS Greater Glasgow and Clyde emerged as not only an aid in this respect, but also served to *create* an opportunity for raising the topic in a non-invasive manner.

4.2 The case for targeting

It is important to acknowledge that only half of those attending the training matched the profile of those initially identified as the key target groups. This is an important finding in view of the fact that early decisions about who should attend the training (or at least, which target groups were considered as priorities) had been based on some consideration of those professionals who would be best placed to effect a reduction in SHS exposure

The findings of this evaluation support a range of assumptions that were made at the outset in relation to who should be targeted. At that time it had been suggested that some professional groups, particularly those with a nursing role, were better placed to effect changes in families' behaviour in relation to SHS.

Given the intended outcome of the training was to effect change in exposure levels, and that such change is more likely if interventions are intensive rather than cursory, and sustained rather than one-off, it is recommended here that:

☞***future training should be targeted at those whose role enable them to proactively raise the issue and provide follow up support to families. Those performing a health visiting role are obvious candidates here.***

The follow up data, both from the questionnaires and the interviews and focus groups provide a strong case for targeting the training at these groups. Furthermore, prior to the training being rolled out, it had been suggested that targeting should be informed by consideration of risk with those working in areas of high deprivation and/or with children with SHS aggravated conditions such as asthma and otitis media with effusion (glue ear) being examples of 'best buys' given the inevitable constraints in terms of the numbers of places available for training. Again, there was some modest support for this: some talked of the presence of such health conditions acting as a catalyst for them to raise the issue, and one interviewee (a health visitor) talked of SHS not being an issue in the locality in which she worked because, she felt, her caseload comprised parents who were highly educated and affluent.

☞***future training should be targeted at those working with large numbers of families whose children are at heightened risk of SHS exposure in the home (such as those living in areas of deprivation) and/or working with children for whom such exposure confers heightened risk (such as those with asthma) e.g. health visiting staff, practice nurses, and clinic/hospital based staff including nurses and audiologists. Community pharmacists may also be a useful target group too.***

4.3 Making the training more effective: if it's not broke, why fix it?

This evaluation has indicated that in its current format, the training was extremely effective in achieving increasing knowledge and strengthening confidence. As a consequence, much of the format should be left alone.

In terms of serving to upskill participants in the actual delivery of the five-point plan, certain weaknesses emerged: in the period between the end of the training and follow up, there was a reduction in confidence in describing the constituents of tobacco smoke, helping families overcome difficulties in making their home or car smoke free and dealing with relapse. Furthermore, and strikingly, in the interviews and focus groups, no-one remembered what the five-point plan entailed. In view of these findings, and a more general difficulty to recollect the content of the training, a need was identified for some form of refresher.

☞***NHS Greater Glasgow and Clyde should consider options to refresh participants' memory. This could take the form of short emails that remind participants of the toxicity of SHS, its effects on children, and which provide updates on any new evidence on risk reduction or sources of support.***

This evaluation has also indicated challenges that practitioners experienced in executing the five-point plan. In the interviews and focus groups, participants talked about difficulties, indeed a lack of confidence, in guiding families through the whole motivational change cycle. They also identified particular scenarios that they found difficult e.g. where families are resistant to taking on board the message that SHS is detrimental to their children's health and/or where they are defensive.

☞ ***NHS Greater Glasgow and Clyde should consider whether and how the training could be developed in order to better upskill (NHS) participants e.g. developing vignettes for discussion and/or options for role play which consider how to encourage and support families who might not initially be amenable to change.***

The findings from this evaluation suggest that the training was less effective in terms of reducing exposure to SHS in the car.

☞***This element of the training should assume more prominence.***

4.4 Getting the message 'right'

The training is premised on the belief that if exposure to SHS in the home and car cannot be eradicated, restriction should be encouraged e.g. smoking in one well-ventilated room in the house. In turn, such restriction is believed to represent a step in the right direction, making *subsequent* elimination of exposure more likely.

This message proved confusing to some participants though, and both in the surveys and the follow up interviews and focus groups, there were calls for better clarity on exactly how the effects of exposure can be reduced: for example, to what extent are children protected if/when parents smoke in another room but then return to the child in the clothes that they were wearing at the time. In turn, many highlighted the need for more information on third hand smoke and its effects.

☞ ***NHS Greater Glasgow and Clyde should seek to keep participants informed of best available evidence not only on SHS, but on third hand smoke too, and importantly, how the associated risks can be reduced. Such information will need to be consistent with any wider (national) messages e.g. if/as developed by the Scottish Government/NHS Health Scotland.***

4.5 Engendering a supportive local context

The training was shown to be effective in increasing the confidence of all, not just those in a health visiting role. As a consequence, there were increases in the likelihood/frequency of participants talking to families about SHS and associated risks. This can only be a good thing, and serve to contribute to increased awareness of SHS (and a common vocabulary) in the CH(C) Ps – an outcome identified in the logic model.

As reported above however, many felt constrained by their role (including the time available within it) to carry out the full five-point plan. For those with roles that involve little opportunity to address SHS exposure in a proactive and sustained manner there may be value in them attending a shorter, and therefore less resource intensive, version of the training. Such training could focus largely on providing information on SHS toxicity and associated risks, and on sources of further support, including (but not restricted to) smoking cessation services. In view of suggestions that families would benefit from attending the training, it may be that any such sessions are extended to the general public if it was felt that these could run successfully with a large number of participants.

☞***NHS Greater Glasgow and Clyde and the CH(C) Ps should consider the desirability and feasibility of such sessions. As such, these should be additional to, and therefore complement those available to the health service staff highlighted previously.***

Provision of the leaflet emerged as an important mechanism to raise awareness and explain the dangers of SHS: many participants felt that this gave them an opportunity or an 'excuse' to broach the topic. This evaluation does not answer the question however as to whether participants would have used the leaflet as frequently (and enthusiastically) if they had simply been issued with copies, but had not attended the training.

Nevertheless, it seems plausible that the training not only made participants aware of the leaflet, but also served to *motivate* them to use it as overwhelmingly interviewees and focus group participants said that the most salient aspect of the training was hearing of the toxic constituents of SHS and as a consequence, understanding the risks that these bring to children's health.

In the follow up interviews and focus groups, a small minority believed that the leaflet was not available in their area, while others highlighted ways in which the leaflet could be adapted in order to make it used more widely.

☞***NHS Greater Glasgow and Clyde and the CH(C)Ps should ensure that NHS staff are aware of the leaflet and how to order it, and seek to distribute the leaflet widely to settings with a high concentration of parents of young children, particularly those at heightened risk e.g. in primary care settings especially those serving large numbers experiencing deprivation, and via antenatal and postnatal services.***

☞In addition, NHS Greater Glasgow and Clyde should perhaps consider making the leaflet available in minority languages. As such, these decisions should be informed by any known information on smoking rates in the key ethnic groups, not only in parents but in those of grandparent-age if reading English is a significant barrier.

4.6 Concluding comments

The training programme has been subjected to quite a testing evaluation: effectiveness has been considered through comparisons of ratings prior to the training, at the end of the training, and importantly, at follow up.

The findings are impressive in many respects: the training has been shown to achieve many of its learning outcomes.

The key issue however, is whether it achieved this on a large enough scale i.e. did it benefit enough of the participants and did it benefit them 'enough'?

To answer this question, NHS Greater Glasgow and its CH(C)Ps need to consider how any sessions should be rolled out in the future in order that those who are trained benefit in ways (and to a level) that are likely to reduce children's exposure to SHS.

The recommendations in this report provide some pointers as to how the training might better address the outcomes to which NHS Greater Glasgow and Clyde and CH(C)Ps aspire.

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