Smoking cessation in later life: an evaluation of the impact of smoking cessation training on the knowledge, attitudes and practice of members of the primary care team who work with older people

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Smoking cessation in later life: An evaluation of the impact of smoking cessation training on the knowledge, attitudes and practice of members of the primary care team who work with older people

- Final Project Report -

Caledonian Nursing & Midwifery Research Centre

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EXECUTIVE SUMMARY

1. Introduction

Smokers aged 65 years and older are a vulnerable group who are likely to have conditions that are caused or complicated by smoking. Older smokers are also likely to die prematurely, losing on average 16 years from their projected life expectancy.

In recent years a growing body of research has demonstrated that older smokers can derive significant health benefits from stopping smoking in later life, despite having smoked for many years. The benefits of cessation are almost immediate for conditions such as heart disease and stroke. Stopping smoking also reduces the risk of developing cancer and stabilises existing conditions such as chronic obstructive pulmonary disease.

Healthcare contacts provide excellent opportunities for smoking-cessation interventions and there is compelling evidence that interventions delivered by health professionals can be effective in triggering and supporting cessation attempts. In the UK, ninety percent of all contacts between members of the public and the NHS take place in the primary care setting, with older adults (≥ 65 years) having contact with members of the primary care team, on average seven times per year. Professionals working in this setting therefore have a crucial role to play in discussing the topic of smoking cessation with older people who smoke.

Unfortunately, despite confirmation of the benefits of smoking cessation in later life and compelling evidence that intervening with older adults can be effective, a number of studies have shown that health professionals, including members of the primary care team, often fail to target this population.

Previous work undertaken by the Research Team has demonstrated that health professionals’ failure to discuss the topic of smoking/smoking cessation can often be the result of limited knowledge of smoking cessation products and services. Professionals have also reported that they do not have the skills required to deliver effective smoking cessation interventions (smoking cessation training is rarely incorporated into undergraduate or post-graduate educational programmes). Finally, pessimistic attitudes towards smoking cessation in later life have been noted, with health professionals often believing that few older people manage to stop smoking successfully.

In light of the above, the current study sought to develop and evaluate specially tailored smoking cessation training for members of the primary care team who work with older people. The aim was to provide professionals with the knowledge and skills required to deliver effective brief interventions.

2. Methodology

The study was undertaken in four phases. Phase I involved the development of the tailored smoking cessation training. The training that was developed has been approved by Partnership Action on Tobacco and Health (PATH) and NHS Education for Scotland (NES). PATH is an initiative, funded by the Scottish Executive and managed by ASH Scotland, which aims to support the implementation of Scottish and UK government policies on tobacco and smoking. NES seeks to enhance the quality of the educational provision for nurses, midwives and allied health professionals in Scotland (i.e. NMAHPS).

The second phase of the study focused on the development and testing of the three data collection instruments that would be used to measure the knowledge, attitudes and
practice of the study participants before and after the training. This phase of the study was important as it ensured that the instruments used to collect the data were both valid and reliable.

The third phase of the study involved the delivery and quantitative evaluation of the training. This element of the study took the form of a randomised controlled trial. The study participants were 73 nurses and allied health professionals recruited from seven Community Health and Social Care Partnerships. The participants included health visitors, district nurses, practice nurses and nurses and allied health professionals working in Community Older People’s Teams. Following stratification, the study participants were randomly allocated to the intervention group (training) or the control group (no training).

The training was delivered by a professional experienced in the delivery of smoking cessation training, during a seven hour study day.

The data were collected using the validated questionnaire at three time points; just before the training (at baseline), one week after the training and three months after the training. The data collected focused on the knowledge, attitudes and practice of the study participants.

The data were analysed using a two factor repeated measure Analysis of Variance (ANOVA), where the main factors were ‘group’ and ‘time’. This statistical test was used to compare the scores of the two groups (i.e. the intervention and the control group) across the three different time points.

The final phase of the study used a qualitative approach to explore, in some depth, the participants’ views of the training and its impact on their practice. Members of the intervention group participated in a one-to-one semi-structured interview, approximately four months after the training. The audio-recorded interviews were analysed thematically using constant comparative procedures.

3. Results

The quantitative assessment of the training demonstrated the following:

- A statistically significant improvement in the knowledge of the intervention group that was maintained over time.
- A statistically significant improvement in the attitudes of the intervention group that was maintained over time.
- A statistically significant improvement in the reported practice of the intervention group that was maintained over time.

The training was therefore found to be effective i.e. it had a demonstrable positive impact on the knowledge, attitudes and practice of the study participants.

The qualitative evaluation of the training confirmed what had been shown in the quantitative results. Prior to the training, members of the intervention group reported limited knowledge and a lack of skills to raise and sustain the subject of smoking/smoking cessation. This often produced a lack of self-efficacy and outcome expectations that focused on failure. Participants’ negative attitudes towards older people stopping smoking also affected their subsequent actions and together these factors strongly influenced their smoking cessation practice. It was evident that the practice of participants who had previous generic smoking cessation training was at a more advanced level when compared to those who had not; however, deficits in knowledge and pessimistic attitudes towards smoking cessation in later life were reported.
The qualitative analysis of the participants' practice after the training clearly demonstrated changes in their practice. These changes were reported as a result of increased knowledge levels, more positive attitudes towards smoking cessation in later life and the skills that had been developed during the training. Enhanced levels of self-efficacy following the training were clearly evident.

4. Discussion/conclusions/recommendations

This study has developed and tested specially tailored smoking cessation training for members of the primary care team who work with older people. The evaluation of the training has demonstrated that it was effective in enhancing the knowledge, attitudes and practice of those who participated in the study.

Previous research has demonstrated that the delivery of brief opportunistic interventions by health professionals is highly cost-effective.

While the need for generic smoking cessation training has been evident for a number of years, the need to develop tailored training for professionals who have contact with key priority groups such as older adults, has been identified more recently. We believe that we are the first group at a UK-wide level to develop and formally test the efficacy of tailored smoking cessation training for professionals who have contact with older adults. We therefore consider that this study makes an important contribution to the current knowledge base.

Following the positive evaluation of the training we recommend that the training be rolled out at a Scotland-wide level. Further evaluative work will be required.
1. Introduction

1.1 Aim and Objectives

The aim of the study was to test the impact of specially tailored smoking cessation training on the knowledge, attitudes and practice of members of the primary care team who work with older adults (≥65 years).

Objectives:

• To develop an evidence-based smoking cessation training package
• To identify/develop valid and reliable data collection instruments to measure the knowledge, attitudes and practice of the study participants
• To deliver the tailored brief intervention training to members of the primary care team who work with older adults
• To evaluate the impact of the training on the study participants’ knowledge, attitudes and practice (in relation to smoking/smoking cessation in later life)

1.2 Background

Smokers aged 65 years and older are a vulnerable group who are likely to have conditions that are caused or complicated by smoking (Kerr et al 2007). Older smokers are also likely to die prematurely, losing on average 16 years from their projected life expectancy (Cataldo 2003).

Although the prevalence of smoking is lower among adults over 65 years than in younger people, the actual number of older smokers is increasing in the developed world, as the proportion of older adults in the population rises. Current estimates suggest that there are around 160,000 smokers aged 65 and over in Scotland, with the number of smokers in this age group expected to rise, unless effective health promotion strategies are implemented (Kerr et al 2004).

In recent years a growing body of research has demonstrated that older smokers can derive significant health benefits from stopping smoking, despite having smoked for many years (Molander et al 2001; Orleans et al 2001). The benefits of cessation are almost immediate for conditions such as heart disease and stroke (Orleans et al 2001). Stopping smoking also reduces the risk of developing cancer and stabilises existing conditions such as chronic obstructive pulmonary disease (British Thoracic Society 1997). Clearly, older smokers are an important target group for smoking cessation interventions.

Healthcare contacts provide excellent opportunities for smoking-cessation interventions and there is strong evidence to suggest that interventions delivered by health professionals can be effective in triggering and supporting cessation attempts (Rice & Stead 2002; Silagy et al 2002; Lancaster et al 2000). In the UK, ninety percent of all contacts between members of the public and the NHS take place in the primary care setting, with older adults (≥ 65 years) having contact with members of the primary care team, on average seven times per year (ISD 2002). Members of the primary care team therefore have a crucial role to play in discussing the topic of smoking cessation with older people who smoke, a point highlighted in the Smoking Cessation Guidelines for Scotland (NHS Health Scotland/ASH Scotland 2004).

Unfortunately, despite confirmation of the benefits of cessation in later life (Molander 2001; Orleans et al 2001), and compelling evidence that intervening with older adults can
be effective (e.g. Ferguson et al 2005), a number of studies have shown that health professionals often fail to target this population (Maguire et al 2000; Ossip-Klein 2000; Watson et al 2004). Of particular note are the results from a Scotland-wide survey of the health promoting activities of members of the primary care team which demonstrated that fewer than 50% of the respondents actively discussed smoking cessation with older adults and that the level of input decreased with age (i.e. the older the smoker, the less likely the health professional was to intervene) (Watson et al 2004).

Previous work undertaken by the Research Team sought to gather information to inform the development of specially tailored smoking cessation training for members of the primary care team who have contact with older adults (Kerr et al 2004, 2006, 2007). The need for specially tailored training is something that has been highlighted in the Strategy for Smoking Cessation Training (PATH/ASH Scotland 2003a) and by ASH Scotland's tobacco and inequalities needs assessment work (ASH Scotland 2005).

The original developmental work undertaken by Kerr et al (2004) explored the knowledge, attitudes and practice of members of the primary care team; it also explored the health beliefs of older smokers. In sum, while the health professionals were generally convinced of the benefits of smoking cessation in later life they often believed that fewer older people manage to stop smoking. A pessimistic view of the smoking cessation success rate of older smokers appeared to negatively influence their practice. In addition, a number of the professionals appeared to lack confidence in their own counselling skills and/or they had a limited awareness of smoking cessation resources and specialist services. This again appeared to preclude the provision of effective brief interventions. Finally, there was generally little awareness of the content of the Smoking Cessation Guidelines for Scotland. The older smokers reported many positive associations with smoking, which often prevented a smoking cessation attempt. The majority of the older smokers were aware that smoking had damaged their health; however, some were not convinced of the association. A common view was that 'the damage was done' and that there was, therefore, little point in attempting to stop smoking. Knowledge of local smoking cessation services was generally poor. Finally, some of the older smokers voiced concern regarding what they perceived as the health risks of using nicotine replacement therapy.

The current study sought to develop and evaluate specially tailored smoking cessation training for members of the primary care team who work with older people. The training was informed by the findings from the above study by Kerr et al (2004) and by other relevant literature e.g. the Standards for Smoking Cessation in Scotland (PATH/ASH Scotland 2003b).

The study was undertaken in the primary care setting. The participants were nurses and allied health professionals working in seven Community Health and Care Partnerships in an NHS Board in the West of Scotland. When the study commenced it was considered that, if the training was found to be effective, the beneficiaries would be two-fold. First, it was hoped that the knowledge, attitudes and practice of the professionals would be enhanced following their participation in the study. Second, and most importantly, we believed that older smokers who had contact with the practitioners who had participated in the study would benefit from their enhanced knowledge and skills, with more older people being encouraged to undertake a smoking cessation attempt.

Ultimately, if found to be effective, the intention is that the training will be rolled out throughout Scotland and therefore that the pool of professionals and older smokers who will benefit will be much wider. The knowledge gained from the study will also be shared with colleagues at national and international levels through the dissemination of the results at conferences and through peer-reviewed and professional publications.
1.3 Project Management

1.3.1 Research Team

Dr Susan Kerr - Reader, School of Nursing, Midwifery & Community Health, Glasgow Caledonian University
Dr Rosemary Whyte - Research Fellow, School of Nursing, Midwifery & Community Health, Glasgow Caledonian University
Professor Hazel Watson - Professor of Nursing, School of Nursing, Midwifery & Community Health, Glasgow Caledonian University
Professor Debbie Tolson - Professor of Gerontological Nursing, School of Nursing, Midwifery & Community Health, Glasgow Caledonian University
Dr Angus McFadyen – Statistician, School of Computing & Mathematical Sciences, Glasgow Caledonian University

The research team was responsible for issues relating to the design and management of the project. Dr Susan Kerr had overall managerial responsibility, with Dr Rosemary Whyte being responsible for key elements of the day-to-day running of the project. Professors Watson and Tolson provided expertise in the fields of health promotion and gerontological practice, respectively. Finally, Dr Angus McFadyen advised on issues relating to statistical analysis, including the psychometric testing of the data collection instruments.

1.3.2 Research Advisory Group

Agnes McGowan/Kirsty Scott - Smoking Concerns, NHS Greater Glasgow & Clyde
Fiona Borrowman - NHS Health Scotland
Julia Quickfall - Queens Nursing Institute Scotland
Liz Duncan - Help the Aged Scotland
Douglas Guest - ASH Scotland (until 2006)
George Laird – Glasgow Healthy City Partnership (until 2006)
Angela Vettraino - Partnership Action on Tobacco & Health (until 2007)
Judith Burchett - Partnership Action on Tobacco & Health (until 2006)
Frances McLaughlin – District Nursing Sister, NHS Greater Glasgow & Clyde
Margaret Martin – Liaison Health Visitor, NHS Greater Glasgow & Clyde
Marion Welsh – Lecturer in practice nursing, Glasgow Caledonian University

The research advisory group worked alongside the Research Team, advising on practice-related issues, policy and strategic developments in the smoking cessation field and issues relating to older adults.

1.3.3. Smoking Cessation Consultant

Ms Charlotte Woods, an experienced smoking cessation trainer, was employed as a Consultant to develop the brief intervention smoking cessation training package, in consultation with members of the research team. Ms Woods also delivered the training.

1.4 Funding Sources and duration of funding

The study was funded by ASH Scotland’s Tobacco and Inequalities (T&I) Initiative - Phase 3 (£15,000 Wave 1 funding and £6,824 Wave 2 funding). Additional funding was provided
by the Glasgow Healthy City Partnership (£10,000) and the Queens Nursing Institute Scotland (£800 to allow the control group to receive training at the end of the study).

The Chief Scientist Office ‘Support for Science Fund,’ administered by NHS Greater Glasgow & Clyde also provided funding to reimburse General Practices for the time that their staff dedicated to participation in the study (i.e. attendance of practice nurses at the training and completion of the questionnaires).

The study commenced in May 2005 and was completed in August 2007.

2. The study

The study was undertaken in four phases. Phase I involved the development of the tailored brief intervention smoking cessation training pack, with Phase II focusing on the development and psychometric testing of the three data collection instruments that would be used to measure the knowledge, attitudes and practice of the study participants before and after the training. The third phase of the study took the form of a randomised controlled trial, evaluating the efficacy of the training. Phase IV comprise a qualitative evaluation of the participants’ views of the training and its impact on their practice. The sections that follow discuss the four phases of the study.

3. Phase I - Development of the training

3.1 The need for training

As discussed previously, the content of the smoking cessation training was informed by developmental work undertaken by Kerr et al (2004). It was also shaped by other relevant literature, including the Standards for Smoking Cessation Training in Scotland (PATH/ASH Scotland 2003b). The Smoking Cessation Guidelines for Scotland state that one of the main purposes of smoking cessation advice delivered by members of the primary care team is to motivate an attempt to stop smoking (i.e. to provide brief interventions) (NHS Health Scotland/ASH Scotland 2004). Treatment of nicotine addiction (i.e. support during a cessation attempt) is best delivered by specialist services (NHS Health Scotland/ASH Scotland 2004). While the key motivational role of primary care professionals has been highlighted, there is a growing recognition of the need to develop their knowledge and skills to enable them to deliver effective brief interventions. The attitudes of professionals are also important, as they impact on the extent to which knowledge is accepted and used (Watson et al 2007).

3.2 The developmental work

The developmental work that preceded this study demonstrated deficits in the knowledge of members of the primary care team linked to smoking/smoking cessation in later life. It also highlighted that some professionals had a limited knowledge of smoking cessation products and services. Negative attitudes were also evident, with professionals believing, for example, that few older people manage to stop smoking successfully.

3.3 The aim and objectives of the training

Linked to the above, the aim of the training was to provide community-based health and social care professionals with the knowledge and skills required to deliver effective brief opportunistic smoking cessation interventions.
The training sought to enable practitioners to:

- Increase their knowledge and awareness around the issue of smoking/tobacco use in later life.
- Consider their role and responsibility in raising the issue of smoking/tobacco use with older adults.
- Critically appraise the effectiveness of brief intervention as a method of initiating behaviour change, and be aware of how this fits with the wider local and national smoking cessation effort.
- Examine their attitudes and reflect on their practice in working with older adults who smoke.
- Acquire appropriate communication skills in support of client assessment and of a smoking cessation attempt.

3.4 PATH Approval

The training package was developed by an experienced smoking cessation trainer (CW), in consultation with members of the Research Team, between August 2005 and January 2006. We also worked closely with members of the Advisory Group who had particular expertise in this area (AV, JB) during this phase of the study. Details of the Learning Outcomes can be found in Appendix 1.

On completion, the training package was submitted to Partnership Action on Tobacco & Health (PATH) for formal approval. PATH is an initiative, funded by the Scottish Executive and managed by ASH Scotland, which aims to support the implementation of Scottish and UK government policies on tobacco and smoking. Part of PATH’s training and development remit is to promote best practice through evidence based training and to increase the quality and consistency of tobacco related training in Scotland. In order to achieve these objectives PATH has developed standards for smoking cessation training, a strategy for smoking cessation training and it has set up an approval scheme for training that is in line with the standards (PATH/ASH Scotland 2003a, 2003b).

Following some minor revisions, the 1-day tailored brief intervention training was approved by both PATH and NHS Education for Scotland (NES) in March 2006.

4. Phase II - Development and psychometric testing of the data collection instruments

Data collection instruments were required that could be used to assess the knowledge, attitudes and reported practice of the study participants prior to and following the delivery of the tailored smoking cessation training. To ensure the validity of the results it was essential that the instruments used to gather the data had been shown to be both reliable and valid.

A review of the literature was undertaken between May and July of 2005 to determine whether any instruments existed that could be used or adapted for the current study. No suitable instruments were identified that could be used to measure the ‘knowledge’ or the ‘practice’ of the study participants in the current study. However, the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ) (Cartwright 1979, 1980) was identified as an instrument that could be adapted to measure the ‘attitudes’ of the participants towards working with older smokers (see below for details).

The data collection instruments were developed and tested between August 2005 and April 2006.
4.1 The development of the instruments

4.1.1 The Knowledge Questionnaire

Linked to the smoking cessation training Learning Outcomes (Appendix 1), the knowledge questionnaire focused on the following areas:

- The prevalence of smoking (Scotland)
- The prevalence of smoking in later life (Scotland)
- The impact of smoking on health in later life
- The benefits of stopping smoking in later life
- The effectiveness of behavioural interventions (including in later life)
- The effectiveness of pharmacological interventions
- Smoking cessation services
- The role of members of the primary care team in the delivery of smoking cessation interventions

The questionnaire that was developed and tested in this phase of the study comprised 25 questions, with respondents being asked to tick a box, that indicated the ‘correct’ answer (Appendix 2). If respondents did not know the answer they were encouraged to tick a box that stated ‘don’t know’ rather than attempting to ‘guess’ the correct answer. One point was awarded for a correct response and no points were awarded for an incorrect response (including a ‘don’t know’ response), the possible range of scores was therefore 0-25, with a score of 25 being the best possible score.

4.1.2 The Attitudes Questionnaire

As indicated above, the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ) (Cartwright 1979; 1980) was identified as an instrument that could be adapted to measure the ‘attitudes’ of the participants towards working with older smokers. The AAPPQ focuses on six aspects of therapeutic attitude, that is:

- role adequacy
- role legitimacy
- role support
- motivation
- self-esteem
- satisfaction

Therapeutic attitudes and commitment to undertake a role are thought to be influenced by practitioners’ concepts of role adequacy, role legitimacy and role support (Shaw et al 1978; Cartwright 1980). Role adequacy refers to practitioners feelings that they have been adequately prepared to undertake a particular role (i.e. that they have appropriate levels of knowledge and skills). Role legitimacy is used to describe the extent to which practitioners regard a particular aspect of work as being their professional responsibility. Role support relates to the support that practitioners believe they receive from colleagues to help them perform their role effectively. It is believed that the presence of these three situational factors enhances motivation to work with particular client groups (e.g. people who smoke) and also expectations of satisfaction and self-esteem when engaging in therapeutic activity (Shaw et al 1978; Cartwright 1980; Watson et al 2007).

The aspects of therapeutic attitude explored using the AAPPQ were considered to be very relevant to the current study which aimed to explore the participants’ attitudes towards working with older smokers. In particular, role adequacy, role legitimacy and motivation seemed central.
As the AAPPQ was initially developed to explore attitudes towards working with problem drinkers, the wording of the questions needed to be altered to reflect the focus on attitudes towards working with older people who smoke. A copy of the revised version of the AAPPQ can be found in Appendix 3.

The revised instrument included a list of 30 statements, with respondents being asked to indicate their strength of agreement with the statements on a 7-point Likert scale. The response options range from Strongly Agree (1) to Strongly Disagree (7). The potential scores therefore ranged from 30 (i.e. 30x1) to 210 (i.e. 30x7). Following the reversal of the scores for 7 questions (i.e. questions 15, 16, 23, 24, 25, 27 and 29), lower scores indicated more positive attitudes towards working with older people who smoke, with higher scores indicating more negative attitudes.

4.1.3 The Practice Questionnaire

The questionnaire that would be used to measure perceived practice focused on what is considered to be ‘good practice’ in the delivery of brief interventions. The construction of this instrument was influenced by recommendations in the Standards for Smoking Cessation Training in Scotland (PATH/ASH Scotland 2003b) and in the Smoking Cessation Guidelines for Scotland (NHS Scotland/ASH Scotland 2004). A copy of the questionnaire that was developed and tested in this phase of the study can be found in Appendix 4. A series of 10 questions were presented that relate to elements of a brief smoking cessation intervention. The questions focused on ‘reported practice’ in the previous week (e.g. “How often did you discuss older smokers’ readiness to stop smoking?”), with respondents being asked to state how often they undertook the 10 listed activities (i.e. always, often, rarely, never). The scoring was as follows:

Always 3 points  
Often 2 points  
Rarely 1 points  
Never 0 points

Possible scores therefore ranged from 0-30, with 30 being the best possible score. In addition, respondents were asked to comment on any contextual factors that prevented or limited their smoking cessation practice (e.g. “I do not generally have time to discuss smoking/smoking cessation”; “I think that there is little to be gained by stopping smoking in later life”).

4.2 The psychometric analysis of the data collection instruments

This element of the study sought to determine the psychometric properties of the three data collection instruments. It was important that the instruments used to assess the knowledge, attitudes and practice of the study participants were both reliable and valid so that any differences in the scores following the intervention were due to the intervention itself rather than extraneous variables, such as the use of unreliable data collection instruments.

4.2.1 Sample Selection & Size

The instruments were tested with a sample of nursing, allied health professional and social work students from the population of pre-registration and post-registration students in a University in the West of Scotland. Following access negotiations, ethics approval was granted by the University Ethics Committee (see Appendix 5 a & b).

All of the students who took part had contact with older people who smoke and therefore had experience that was appropriate when assisting with the testing of the instruments. They were either in their final year of undergraduate education or were already registered
practitioners who were undertaking post-graduate education. The size of the population was c.500.

Power calculations were undertaken to determine the size of the sample that was required for the psychometric testing of the instruments. Statistical power was calculated for the simple case of two response categories (Agree or Disagree) in the attitude questionnaire for which the Sign Test is equivalent to McNemar's Test (Bland 1995). Assuming the population proportion giving the same response on both occasions was 0.7, a sample size of 336 would ensure that the probability of detecting a difference of 0.1 between the two proportions was 0.91 (i.e. a power of 91%).

An additional factor that was taken into account when considering the sample size requirements was the number of participants required to provide a stable factor analysis. Field (2000) recommends that a minimum sample of 10 participants be recruited per variable. Basing calculations on the longest instrument, which had 30 items, a sample of 300 would be required.

Our aim, therefore, when recruiting participants was to have a sample size of at least 336. Allowing for a level of attrition, we sought to commence the psychometric testing with c. 350-375 participants.

4.2.2 Data collection

The questionnaires were handed out at the end of lectures with an Information Sheet that provided full details of the study including why the students were being asked to participate (Appendix 6). The students were asked to complete the questionnaires before leaving the classroom and to deposit the completed questionnaires in a sealed box specially prepared for this purpose. Completion and the return of the questionnaires was taken as evidence of consent.

Data were collected from the students at two time points, two weeks apart as the test-retest reliability of the instruments was being examined in addition to other tests of validity and reliability. When assessing the test-retest reliability of an instrument, the interval between the two administrations of the instrument should be long enough for the participants to forget the specific responses which they gave on the first occasion but not long enough for a change to have occurred in their knowledge/attitudes/practice. De Vaus (1993) suggests that a period of two weeks is an acceptable interval.

To assist the matching of respondents from Time 1 and Time 2 for test-retest reliability, the respondents were asked to provide their date of birth and their house number in specially prepared boxes on the front page of the questionnaire. This method of identification was chosen to reduce any concerns that the respondents may have had that their identity would be uncovered (i.e. we did not wish to use matriculation numbers). In this way, the anonymity of the respondents was maintained and confidentiality assured.

4.2.3 Data analysis

The data were coded and entered into the Statistical Package for the Social Sciences (SPSS version 14). The accuracy of the data input was checked. The analysis of the data was guided by a member of the Research Team who is a statistician (AMcF).

The following analysis was undertaken:

Knowledge questionnaire: stability/test-retest reliability (kappa, sign test, intra-class correlations); content validity
**Attitude questionnaire**: stability/test-retest reliability (weighted kappa, sign test, intra-class correlations); internal consistency (Cronbach’s Alpha); content validity; construct validity (principal components analysis)

**Practice questionnaire**: stability/test-retest reliability (kappa, sign test, intra-class correlations); content validity

Kappa, the weighted kappa and the sign tests were used to compare individual items when assessing test-retest reliability. Kappa was used when assessing dichotomous variables (i.e. correct/incorrect answers in the knowledge questionnaire) and the weighed kappa was used when assessing scaled responses (i.e. in the attitude and practice questionnaires). Intra-class correlations (ICCs) were used to compare total scores when assessing test-retest reliability.

As the attitude questionnaire included an overall scale and a number of sub-scales/factors (e.g. role adequacy, motivation) it was appropriate to assess internal consistency and construct validity. These tests were not appropriate for the knowledge and practice questionnaires.

### 4.3 Results of the psychometric analysis

A total of 376 participants completed the questionnaires at Time 1, with 250 completing at Time 2. Four of the Time 2 questionnaires could not be matched with Time 1 questionnaires and so were not able to be utilised to assess the stability/test-retest reliability of the instruments.

#### 4.3.1 Knowledge questionnaire

**a) Stability/test-retest reliability**

The kappa values for the 25 individual questions in the knowledge questionnaire ranged from 0.3 to 0.6. The cut off point below which values are not considered acceptable is 0.2 (Landis & Koch 1977). No items were therefore removed from the questionnaire on the basis of poor test-retest reliability. The ICC value for the total knowledge scores was 0.76 (95% CI 0.71-0.81), indicating that the questionnaire as a whole had excellent test-retest reliability (Shoukri & Edge 1996).

**b) Content validity**

Following completion of the first draft of the questionnaire members of the Research Advisory Group with particular expertise in relation to smoking/smoking cessation and smoking cessation training were asked to comment on the content and the layout of the questionnaire. Each of the seven members of the group who assisted with this element of the study was asked to complete a standardised response sheet that asked about the clarity of the questions, whether the questionnaire appeared to be comprehensive and whether anything should be removed. Some minor alterations were made to the questionnaire following receipt of the comments.

In addition to the early involvement of the expert group, all of the participants (i.e. the students) who assisted with the psychometric testing of the instruments were asked to complete a 1-page sheet where they were asked to highlight any questions that were difficult to understand, to make suggestions for anything that they felt should be added and to make any additional comments that they considered relevant.

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1 NB The ICC value for the final version of the knowledge questionnaire (see p10) was 0.73 (95% CI 0.66-0.78) indicating that the shortened version of the instrument had ‘good’ test-retest reliability.
Of the 376 participants who completed the questionnaire at Time 1, 343 commented on the content and layout of the questionnaire. Eighty-three percent of these respondents (n=286) stated that the questions were easy to understand and complete. The main issues raised were that if people did not know the answers they may guess. Also, a small number of respondents felt that the questionnaire was rather long (n=4). One respondent commented that the font size was too small. Ninety-four percent (n=309) of the respondents stated that they felt that the questionnaire was comprehensive and that no questions should be added.

**c) Revisions to the knowledge questionnaire**

One issue that was highlighted when testing the psychometric properties of this instrument was that a high percentage (i.e. >70%) of respondents answered seven of the questions correctly (i.e. Q5 a,b,c,e,f,n,u). This indicated that these questions were too easy and they were therefore removed from the questionnaire. As the aim of the intervention in this controlled trial was to increase knowledge levels linked to smoking/smoking cessation in later life, there was little point in including questions where a high proportion of the respondents (with or without an intervention) were likely to know the answer. Removing these questions had the added advantage of shortening the questionnaire.

The final 18 item version of the questionnaire that was used in the randomised controlled trial can be seen in Appendix 7. In addition to shortening the questionnaire the font size was increased to ensure ease of completion and the wording of one question was altered slightly to assist clarity.

**4.3.2 Attitudes Questionnaire**

**a) Stability/test-retest reliability**

The weighted kappa values for the original 30 questions (items) in the attitudes questionnaire ranged from 0.15 to 0.29. Again, the cut off point, below which values were not considered acceptable was 0.2 (Landis & Koch 1977). As there was a scaled response to the items in the questionnaire the stability of the instrument was also assessed using the sign test. The sign test (at 5% level of significance) was used to assess if any sequential shift took place between test and re-test data collection.

A number of items (n=14) were removed on the basis that they had poor test-retest reliability. The items that were removed were questions 7, 10, 11, 14, 16, 18, 19, 20, 21, 24, 27, 28, 29, and 30.

The ICC value for the total attitude scores (before any items were removed) was 0.85 (95% CI 0.79-0.89). This value indicated that the questionnaire as a whole had ‘excellent’ test-retest reliability (Shoukri & Edge 1996).2

**b) Construct Validity**

A principal components analysis (PCA) using Varimax rotation was used to assess the construct validity of the 16 remaining items in the attitude questionnaire. This resulted in a four factor solution. Items 8 and 9 had a poor fit and were removed. Tabachnick and Fiddell (2001) suggest that an item loading on a PCA of less than 0.55 indicates that the item is a poor measure of the sub-scale. This left 14 items in the questionnaire. The PCA

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2 NB. The ICC value for the final 12 item version of the attitude questionnaire (see p11) was 0.77 (95% CI 0.70-0.82), indicating the shortened version of the instrument still had excellent test-retest reliability.
was then re-run with the 14 items. This resulted in a 3 factor solution, with items 15 and 17 having a poor fit. These items were therefore removed. The PCA was then re-run with 12 items. This resulted in the final 3 factor solution.

The version of the instrument that has been shown to have high levels of construct validity therefore has 12 items. The three factors that the instrument explores are role adequacy, role legitimacy and motivation.

c) Internal consistency

Following the reduction of the instrument to 12 questions its reliability in terms of internal consistency was estimated using Cronbach’s $\alpha$ coefficient. The alpha coefficient for the entire 12 item instrument was found to be 0.81. Levels above 0.7 are regarded as satisfactory (Bland and Altman 1997).

d) Content Validity

In addition to the early involvement of an expert group, all of the participants who assisted with the psychometric testing of the instruments assisted with the evaluation of the content validity of the attitude questionnaire.

Of the 376 participants who completed the 30 item questionnaire at Time 1, 343 commented on the content and layout of the questionnaire. Eighty-three percent of these respondents (n=286) stated that the questions were easy to understand and complete. However, 17% (n=57) stated that they had some difficulties with the questionnaire. The main concerns were that the questionnaire was lengthy, that the font size was small and that there was little space between the questions. A small number of respondents also stated that the clarity of the wording in some of the questions could be improved (i.e. Q1, 16, 18, 19, 20).

e) Revisions to the attitude questionnaire

As stated above, following the assessment of the reliability and validity of the attitude questionnaire it was reduced from a 30-item questionnaire to a 12-item questionnaire (see Appendix 8). The questions highlighted above as causing concern in relation to content validity had been removed during the assessment of the construct validity and therefore no re-wording was required. As a number of respondents had commented on the layout of the questionnaire and the font size, the layout was altered from landscape to portrait (this then aligned with the layout of the other two questionnaires) and the font size was increased.

4.3.3 Practice questionnaire

a) Stability/test-retest reliability

The weighted kappa values for the 10 items in the practice questionnaire ranged from 0.35 to 0.49. Again, the cut off point, below which values were not considered acceptable was 0.2 (Landis & Koch 1977). No items were removed on the basis of poor test re-rest reliability.

The ICC value for the total practice scores was 0.84 (95% CI 0.8-0.88). This value indicated that the questionnaire as a whole had ‘excellent’ test-retest reliability (Shoukri & Edge 1996).
b) Content validity

Again, the majority of the respondents felt that the questions in the practice questionnaire were easy to understand (83%). The main negative comments related to the size of the font.

c) Revisions to the practice questionnaire

The only revision that was made to this questionnaire was an increase in the font size (see Appendix 9).

On completion of the psychometric analysis of the original three questionnaires, three valid and reliable instruments had been developed that would be used to evaluate the efficacy of the smoking cessation training in the next phase of the study.

5. Phase III - Evaluation of the training (RCT)

5.1 Methodology

5.1.1 Design

The quantitative evaluation took the form of a randomised-controlled trial (RCT). A pre-test post-test design was used, with participants being randomly allocated to the intervention group or the control group for the purpose of comparison.

5.1.2 Ethics approval

Applications for ethics approval for the quantitative and qualitative elements of the study were submitted to the NHS Board in December 2005 and November 2006 respectively. Ethics approval was granted (see Appendix 10 & 11). Following ethics approval Research & Development approval was also sought and granted (Appendix 12 & 13).

5.1.3 Hypotheses

When undertaking the quantitative evaluation, the following hypotheses were tested:

That following the delivery of the smoking cessation training:

- There would be a statistically significant difference in the mean scores of the intervention group and the control group in relation to: a) knowledge; b) attitudes; and, c) practice.
- Any differences in the knowledge, attitudes and practice scores would be maintained over time (i.e. differences at 1 week post-training would be maintained at 3 months post-training)

5.1.4 Population and sample

The sample was drawn from the total population of district nurses, health visitors and practice nurses working in the eleven Community Health and Care Partnerships (CHCPs) in an NHS Board area in the West of Scotland in June 2006 (n=1127). The population also included nurses, allied health professionals and social workers working in the Community Older People’s Teams in the CHCPs (n=56).
5.1.5 **Sample selection and size**

Members of the primary care team (as detailed above) were selected from seven of the eleven CHCPs in the NHS Board. Attempts were made to ensure that the CHCPs that were chosen included areas with differing levels of socio-economic deprivation (McLoone 2004) and were therefore representative of the NHS Board area.

The inclusion criteria were as follows:

- District nurses/support nurses (Grades D-G)
- Health visitors/support nurses (Grades D-G)
- Practice nurses (Grades F-G)
- Nurses in Community Older People’s Teams (Grades E-G)
- Physiotherapists, occupational therapists, podiatrists, dieticians, pharmacists in Community Older People’s Teams (Grade Senior 1)
- Social Workers working in Older People’s Teams (Grade, equivalent to Senior 1)

Participants must also have been having regular (at least weekly) contact with older people (≥65 years).

When assessing whether the training was effective it was essential that the size of the sample was sufficient to demonstrate a statistically significant difference between the intervention and control groups following the delivery of the training (if indeed a difference did exist).

Power calculations were undertaken based on estimated changes in the attitude scores (AMcF). A change of five points in the attitude sub-scale that measures ‘role-adequacy’ was hypothesised. As the possible range of scores in this scale is 60, a 5 point change would represent a shift of 8.33%. Previous work undertaken by members of the Research Team (using another version of this instrument), suggested that this level of change was likely to be a conservative estimate (Watson et al 2003).

The power calculations indicated that 70 participants were required i.e. 35 in each group. This number of participants would yield a statistical power in excess of 80%, with the level of statistical significance being 5%. To allow for a level of attrition following initial recruitment, efforts were made to recruit c. 80 participants.

5.1.6 **Recruitment**

To ensure that the conditions of the Data Protection Act (1998) were observed, participants were recruited with the assistance of senior managers in the seven Community Health & Care Partnerships. These managers included senior nurses, lead nurses, COPT co-ordinators and the Practice Nurse Advisor (NHS Board area). The managers agreed to distribute study information packs to all district nurses, health visitors, practice nurses and Community Older People’s Teams in the seven CHCPs.

The information packs contained a letter of invitation (Appendix 14), an information sheet (Appendix 15) and a consent form (Appendix 16). Professionals who wished to participate in the study were asked to sign and return the consent form.

In total, 783 information packs were distributed between June and August 2006.

Following the distribution of the study information packs a total of 113 responses were received. Seventy-three respondents stated that they wished to participate in the study, with 40 declining the invitation. When recruiting study participants we were aware that a
number of health visitors have very limited contact with older people. We had therefore encouraged the professionals to let us know if they did not meet the study inclusion criteria (i.e. if they did not have regular contact with older people). Thirty-two of the participants who declined the invitation to participate in the study did so on the basis that they did not have regular contact with older people. Seven professionals declined on various other grounds, including heavy workload and one participant stated that she did not consider that the provision of smoking cessation advice was part of her role.

5.1.7 Stratification and random allocation to groups

Stratified random sampling was used to allocate study participants to the intervention group or the control group. Stratification was used for two reasons:

- To achieve a balance of professional representation within both groups (i.e. nurses, allied health professionals, social workers)
- To achieve a balance within both groups based on any previous smoking cessation training

Following stratification, the study participants were randomly allocated to either the intervention or the control group.

5.1.8 The delivery of the intervention

The training was delivered during a seven hour study day. In order to facilitate the small-group work required for effective training, the intervention group (n=28) was divided into three groups, with the participants being asked to choose to attend one of three training days in August and September 2006.

The training was delivered by an experienced smoking cessation trainer (CW). An outline of the training can be found in Appendix 17.

5.1.9 Data collection

The data were collected at three time points, referred to as Time 1, Time 2 and Time 3.

- At Time 1, the questionnaire was completed by intervention group participants prior to the commencement of the smoking cessation training. It was completed at the same time by the control group participants who had received it by post.
- At Time 2, the questionnaire was sent to all participants by post one week after each training day.
- At Time 3, the questionnaire was sent to all participants by post three months after the training.

Participants were asked to complete the questionnaires on their own and not to discuss their responses with others. At each of the time points, participants who had not returned their questionnaires within 3 weeks were reminded by telephone/letter and this resulted in an increase in questionnaire returns.

The Consort diagram below (Figure 1) provides information on the number of questionnaire returns at each of the three time points.
While 73 participants had initially agreed to participate in the study and had been randomly allocated to the two groups, 16 of this number were lost to the study prior to the collection of the Time 1 data. Reasons for withdrawal included work commitments precluding attendance at the training day, ill-health and changes in roles resulting in the professionals no longer having contact with older people on a regular basis. At the time of recruitment, changes were occurring in the NHS Board which resulted in some Health Visitors and Support nurses being withdrawn from their contact with older people. Additionally, while they had initially agreed to participate in the study, two members of the control group failed to complete the data collection instruments at Time 1.

As indicated, the number of questionnaires received at Time 1 was 57 (28 intervention; 29 control). One member of the intervention group failed to return the Time 2 and 3 questionnaires. Finally, there was a small attrition rate in the control group.

5.1.10 Data analysis

Data from the three time points were entered into the Statistical Package for Social Sciences (SPSS version 14). Prior to commencement of the analysis, the data entry was checked for accuracy.

Descriptive statistics were used to identify frequencies, measures of central tendency (mean scores) and dispersion (standard deviation).

A two factor repeated measure Analysis of Variance (ANOVA) was used to analyse the data, where the main factors were 'group' and 'time'. The assumptions of normality and homoscedasticity were checked and found to be satisfactory for each of the dependent variables (i.e. knowledge, attitudes & practice). The level of statistical significance was set at 5%. The ANOVA highlights where there is a significant difference between levels of the main factor means but does not indicate between which of the levels there is a difference. Tukey's post-hoc test was therefore conducted to examine the main ‘time’ factor means in more detail, i.e. to explore where exactly the differences existed. Finally,
within group follow-up tests were undertaken (paired t-tests) and as there were 3 comparisons, the level of significance for this element of the analysis was set at 1.7% (i.e. 5%/3) using a Bonferroni correction factor.

5.2 Results

5.2.1 The study participants

Details of the professionals who participated in the study are presented in Table 1. The variables include professional group, mean age and previous smoking cessation training. As indicated, the demographic variables of the intervention group and the control group participants are very similar.

<table>
<thead>
<tr>
<th>Professional group (frequencies)</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Age (mean)</td>
<td>46</td>
<td>44</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous training (frequencies)</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>1 day (brief intervention)</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Maudsley (intensive intervention)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

5.2.2 Knowledge

The mean knowledge scores at the three data collection time points are highlighted in Table 2. The lowest possible knowledge score was 0, with the highest possible score being 18.

<table>
<thead>
<tr>
<th>Time point</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Scores</td>
<td>SD</td>
</tr>
<tr>
<td>Time 1</td>
<td>8.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Time 2</td>
<td>14.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Time 3</td>
<td>13.2</td>
<td>2.1</td>
</tr>
</tbody>
</table>

The differences in the mean knowledge scores at the three time points are also presented graphically in Figure 2.
The repeated measure ANOVA indicated statistically significant effects in knowledge scores for ‘group’ (F = 54.8, df = 1, p<0.001) and for ‘time’ (F = 20.776, df = 2, p=0.001).

Tukey’s post-hoc test confirmed the presence of a ‘time’ effect, with the comparisons (i.e. Time 1 v Time 2 and Time 1 v Time 3) being very significant (p< 0.001). Within group follow-up tests are reported in Table 3.

Table 3 – Within Group Follow-up Tests (Knowledge)

<table>
<thead>
<tr>
<th>Time comparisons</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean diff.</td>
<td>s.d.</td>
</tr>
<tr>
<td>T1 v T2</td>
<td>-5.8</td>
<td>3.7</td>
</tr>
<tr>
<td>T1 v T3</td>
<td>-5.1</td>
<td>3.9</td>
</tr>
<tr>
<td>T2 v T3</td>
<td>0.8</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Allowing for a multiple testing correction factor, using p-values less than 0.017 as being significant, the statistical analysis of the knowledge scores confirmed a significant increase for only the intervention group mean scores over time. This increase was maintained given that both the ‘pre-training to 1 week post training’ and the ‘pre-training to 3 month follow-up’ comparisons are both very significant (p<0.001).

A full breakdown of the responses to the individual questions in the knowledge questionnaire can be found in Appendix 18.

5.2.3 Therapeutic attitudes

The mean attitude scores at the three data collection time points are highlighted in Table 4. The lowest possible attitude score was 12, with the highest possible score being 84. The lower the score, the more positive the attitudes.

Table 4 – Mean Attitude Scores

<table>
<thead>
<tr>
<th>Time point</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Scores</td>
<td>SD</td>
</tr>
<tr>
<td>Time 1</td>
<td>40.2</td>
<td>11.4</td>
</tr>
<tr>
<td>Time 2</td>
<td>25.2</td>
<td>7.9</td>
</tr>
<tr>
<td>Time 3</td>
<td>27.4</td>
<td>11.2</td>
</tr>
</tbody>
</table>
The differences in the attitude scores at the three time points are represented graphically in Figure 3.

![Figure 3 - Therapeutic Attitudes](image)

The repeated measure ANOVA indicated statistically significant effects in attitude scores for ‘group’ (F=30.701, df=1, p<0.001) and ‘time’ (F=14.217, df=2, p<0.000).

Tukey’s post-hoc test confirmed the presence of a time effect, with the comparisons (i.e. Time 1 v Time 2 and Time 1 v Time 3) being very significant (p < 0.001). Within group follow-up tests are reported in Table 5.

<table>
<thead>
<tr>
<th>Time Comparisons</th>
<th>Mean diff.</th>
<th>s.d.</th>
<th>p value</th>
<th>95% CI</th>
<th>Mean diff.</th>
<th>s.d.</th>
<th>p value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1 v T2</td>
<td>14.8</td>
<td>9.2</td>
<td>&lt; 0.001</td>
<td>11.0, 18.5</td>
<td>-1.0</td>
<td>5.3</td>
<td>0.340</td>
<td>-3.1, 1.1</td>
</tr>
<tr>
<td>T1 v T3</td>
<td>13.0</td>
<td>11.6</td>
<td>&lt; 0.001</td>
<td>8.3, 17.6</td>
<td>-0.3</td>
<td>6.0</td>
<td>0.817</td>
<td>-2.8, 2.2</td>
</tr>
<tr>
<td>T2 v T3</td>
<td>-2.2</td>
<td>7.7</td>
<td>0.145</td>
<td>-5.3, 0.8</td>
<td>0.9</td>
<td>6.3</td>
<td>0.517</td>
<td>-1.9, 3.6</td>
</tr>
</tbody>
</table>

As before, only p-values of less than 0.017 were considered to be statistically significant. The statistical analysis of the attitude scores confirmed a significant increase for only the intervention group mean scores over time. This increase was maintained, given that both the ‘pre-training to 1 week post training’ and the ‘pre-training to 3 month follow-up’ comparisons were both very significant (p < 0.001).

A full breakdown of the responses to the individual questions in the attitude questionnaire can be found in Appendix 19.

### 5.2.4 Reported practice

The mean practice scores at the three data collection time points are highlighted in Table 6. The lowest possible practice score was 0, with the highest possible score being 30. The higher the score, the ‘better’ the reported practice.
Table 6 – Mean Practice Scores

<table>
<thead>
<tr>
<th>Time point</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Scores</td>
<td>SD</td>
</tr>
<tr>
<td>Time 1</td>
<td>17.8</td>
<td>6.9</td>
</tr>
<tr>
<td>Time 2</td>
<td>20.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Time 3</td>
<td>20.8</td>
<td>7.0</td>
</tr>
</tbody>
</table>

The differences in the practice scores at the three time points are also represented in Figure 4.

Figure 4 - Mean Reported Practice scores

The repeat measure ANOVA indicated statistically significant effects in practice scores for 'group' ($F=16.254$, df=1, $p<0.000$) but not for 'time' ($F=1.109$, df=2, $p=.333$).

With no significant time effect in this model, only within group follow-up tests were considered and the results are reported in Table 7.

Table 7 – Within Group Follow-up Tests (Practice)

<table>
<thead>
<tr>
<th>Time Comparisons</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean diff.</td>
<td>s.d.</td>
</tr>
<tr>
<td>T1 v T2</td>
<td>-2.7</td>
<td>4.2</td>
</tr>
<tr>
<td>T1 v T3</td>
<td>-2.9</td>
<td>5.3</td>
</tr>
<tr>
<td>T2 v T3</td>
<td>-0.2</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Considering only those $p$-values less than 0.017 as being significant, the statistical analysis of the Practice scores indicated a significant increase for only the intervention group mean scores between ‘pre-training and 1 week post-training’ ($p=0.002$) and between ‘pre-training and 3 months follow-up’ ($p=0.009$). This suggests that the increase was maintained.

A full breakdown of the responses to the individual questions in the practice questionnaire can be found in Appendix 20.
5.3 Summary

The quantitative analysis has demonstrated a significant improvement in the knowledge, attitudes and practice of the intervention group following the delivery of the tailored smoking cessation training, which was maintained over time. The next phase of the study provides a more detailed analysis of the participants’ practice.

6. Phase IV - Evaluation of the training (qualitative study)

6.1 Aim and objectives

The broad aim and objectives of the study as a whole are stated in Section 1.1. The aim of the qualitative element of the study was to explore the views of the intervention group participants on the smoking cessation training and any subsequent alterations to their practice. By exploring their views, in some depth, it was considered that data would be gathered that could a) add depth to the quantitative results and b) provide an additional explanatory element to the quantitative results. While the use of quantitative approaches are essential when evaluating the efficacy of an intervention, they are limited in that they provide information on ‘what’ has occurred but not ‘why’. The mixed method evaluation approach adopted in this study is considered to provide a more comprehensive evaluation of the training and is in line with what is recommended by Kirkpatrick (1998).

Specifically, the objectives for the qualitative study were:

- To explore the participants’ views of the training package
- To identify factors that may have enhanced the participants’ practice in relation to the delivery of smoking cessation interventions following the training
- To identify factors that may have presented barriers to the participants’ practice in relation to the delivery of smoking cessation interventions following the training.

6.2 Methodology

6.2.1 Qualitative approach and theoretical underpinnings

The qualitative approach used in this element of the evaluation of the training was informed by Social Cognitive Theory (Bandura, 1986). This theory views human behaviour in terms of a dynamic and reciprocal model in which behaviour, personal factors and environmental influences interact.

Social Cognitive Theory proposes that behaviour and behaviour change (in this case the behaviour of the study participants) are affected by environmental influences, personal factors and attributes of the behaviour itself (Schwarzer & Fuchs, 1995). Each may affect or be affected by either of the other two. A central tenet of social cognitive theory is the concept of self-efficacy. A person must believe in his or her own capability to perform a particular behaviour (i.e. s/he must believe that s/he has the knowledge and skills to raise the issue of smoking cessation and provide information and advice) and s/he must perceive an incentive to do so (i.e. the person’s positive expectations from performing the behaviour must outweigh any negative expectations). Additionally a person must value the outcomes or consequences that he or she believes will occur as a result of performing a specific behaviour (i.e. s/he must believe that triggering a cessation attempt is worthwhile). Outcomes may be classified as having immediate benefits (i.e. training has given confidence to provide appropriate information and advice to patients/clients) or long-term benefits (i.e. patients/clients eventually manage to stop smoking).
6.2.2 Sample selection and recruitment

All members of the intervention group who had undertaken the training and had returned completed questionnaires at the three time points (n=27) were invited to participate in this additional qualitative element of the evaluation. An Information Pack was forwarded which included an Information Sheet (Appendix 21) and Consent Form (Appendix 22). Professionals who wished to participate were asked to sign and return the consent form in the stamped addressed envelope provided. A reminder letter was sent three weeks later to those who had not initially agreed to participate. Ten members of the intervention group initially consented to participate in this element of the study, however one was subsequently unable to participate because of workload issues and another because of ill-health.

6.2.3 Data collection

All eight participants were interviewed at their place of work, in a quiet and private environment. Data were collected approximately 4-5 months after the training was delivered. An interview schedule (Appendix 23) was developed for the study that focused on three areas: a) the participants’ smoking cessation practice before the training, b) the participants’ views of the training and c) the participants’ smoking cessation practice after the training. The data were collected during an individual semi-structured interview. The audio-recorded interviews lasted between 30 and 55 minutes.

6.2.4 Data preparation and analysis

The first stage in the analysis process involved the transcription of the interviews. Once each transcript was complete, the content was checked for accuracy. The data were then entered into the qualitative software package QSR NVivo v.7.

First level analysis involved grouping the data from the eight interviews under the question headings in the interview guide. The data were then categorised into knowledge, attitudes and practice. The third level of analysis involved a search for recurring themes. As discussed previously this process was guided by social cognitive theory i.e. the researcher who was analysing the data sought to explore the reciprocal relationships between personal factors (e.g. knowledge levels), environmental factors (e.g. work pressures) and behaviour (i.e. the professionals’ smoking cessation practice).

The initial analysis was undertaken by RW. To enhance the credibility of the findings, the analytical process was subject to independent peer review by two other members of the Research Team (SK & HW).

6.3 Qualitative Findings

6.3.1 The research participants

As discussed, eight members of the intervention group participated in this element of the study. Seven of the participants were nurses and one was an allied health professional. Four participants had undertaken some previous training in smoking cessation; three had completed a one-day course on brief smoking cessation interventions/motivational interviewing and one had completed training which prepares professionals to deliver intensive group-based smoking cessation interventions. None of the training courses had been specific to older people. The change in the quantitative scores (knowledge, attitudes and practice) of these eight participants (pre and post-training) suggests that there was variation in the sample i.e. moderate to large changes in the quantitative scores were evident. This is important as it suggests that the sample was broadly representative of the wider intervention group.
6.3.2 The impact of the training on practice

The participants’ descriptions of their practice before the training are compared below with their descriptions of their practice following the training. Their views of the training itself are also presented. Participant numbers are used to identify which interviews the quotes are taken from, with ‘NPT’ highlighting that the participants had not undertaken any smoking cessation training previously and ‘PT’ highlighting that the participants had undertaken generic training previously.

a) Before the training

Reported practice

All of the participants reported that before they undertook the training they asked the older people with whom they had contact, whether they smoked. This was generally undertaken at first visits and where it was part of an assessment process. Questions about smoking status were prompted by questions in assessment documentation used during home visits or on computer software used in GP surgeries. However, while patients/clients were asked whether they smoked, the subject was often not discussed any further. The excerpts from the interviews below illustrate that asking patients/clients about their smoking status was sometimes the beginning and the end of the subject.

The first member of the team who sees a new person almost always does [an assessment] …… You might have just asked the person’s smoking status and stopped. (07; NPT)

I would have raised the issue of smoking on my assessment visit but I probably didn’t pursue the issue. (01; NPT)

I would mention, have you thought of giving up smoking, but that would be as far as it went really, because I didn’t know anything else. (05; NPT)

The information and advice on smoking/smoking cessation provided prior to the training was quite variable. The level of advice appeared, to a certain extent, to be dependent on whether or not the participants had had any previous smoking cessation training. As can be seen, the following participants provided very limited information and advice.

I probably didn’t provide any (information/advice), as I didn’t really know anything about it. (05; NPT)

I would give them some advice but probably not a great deal. (03; NPT)

While others who had undertaken some training previously provided more input.

If they were able to come we would ask them to attend the NRT clinic which would run weekly in the health centre. If they were housebound we would give them advice at home and we would get a prescription (for NRT). (04; PT)

I had leaflets, I had phone numbers to hand, where the Smoking Concerns groups were in the area. (06; PT)

Factors that influenced practice

The participants were asked to comment on the factors that they felt influenced their practice prior to undertaking the tailored smoking cessation training. Linked to social cognitive theory, our interest was in the interplay between personal factors (such as
knowledge, attitude and skills), environmental factors (e.g. the attitudes of older people) and the behaviour of the study participants (i.e. their smoking cessation practice).

Participants, who had no previous training, generally indicated that they had limited knowledge of smoking/smoking cessation and they therefore found themselves at a disadvantage when it came to discussing the subject with patients/clients.

I suppose it was my knowledge, which was very limited, that was obviously a big issue because I couldn’t really go into much detail or have much of a conversation with them. (05; NPT)

I felt I had a certain degree of knowledge but quite a few facts and figures I didn’t have and how to approach the person, I didn’t have. (01; NPT)

Limited knowledge was also closely linked to the participants’ lack of confidence in their skills to discuss the subject beyond the initial questions, especially with older patients/clients.

I suppose I just wouldn’t really have considered discussing it in any depth at all, so yeah I suppose you could say that was a lack of confidence in not wanting to discuss it. (05; NPT)

As discussed previously, four participants had some previous smoking cessation training, although none of the courses had been specific to older people. These participants believed that their knowledge of smoking cessation issues was generally satisfactory prior to the tailored training; however, they identified knowledge deficits linked to smoking cessation in later life.

I didn’t know the prevalence (of smoking in later life). (08; PT)

(I learned about) raising the issue with older adults .... so all that gave me a better understanding of it. Cos the (training that I had previously) didn’t really cover the elderly, it covered all age groups. This (training) specified over 65 and the role of (generic staff). The focus (was) on the elderly. (02; PT)

The success rate (in later life) is far more than I thought it would be .... I didn’t think it was as good as that. (08; PT)

The fact that all these other chemicals were in these cigarettes and doing whatever damage they do then if I knew it before then I hadn’t given it the credence that I gave it after learning about it that day. (06; PT)

A further influence on practice prior to the training was the participants’ attitudes. Negative attitudes about the success rate of smoking cessation in later life appeared to restrict the information and advice given to patients/clients. Several participants believed that older people would not be able to stop smoking because of the number of years they had been smoking and the fact that they were generally heavily addicted to nicotine.

I had pre-conceived ideas that – what’s the point they are quite happy with their smoking. (01; NPT)

I just felt that they had probably been smoking for years so probably had no intention of giving up, so it never really, I never really thought much about that side of things. (05; NPT)
Anybody in the sort of older age group I probably always advised them about smoking, stopping smoking, all the rest of it. But really what I thought was what’s the point, because you know it’s too late now to give up. (08; PT)

One participant believed that when older people had difficult and complicated lives they had other priorities to deal with rather than tackling their smoking habit.

Some of them have got many other problems and you’re trying to help them with that (rather than encourage them to stop smoking). (03; NPT)

The reported attitudes of older people themselves were also viewed as a barrier to the provision of smoking cessation interventions.

There will be people who will say “No, I will smoke….. I’ve done it all these years, I’ve been doing it for 50/60 years and there’s no point now (in stopping)”. (02; PT)

The most common barrier is straight away “I don’t want to stop”. Perhaps they’ve tried in the past but more are likely to say this is one of the few pleasures they have. (07; NPT)

They don’t believe what the doctor says, because a lot of them think they know better and that they’ve smoked 50 years and it hasn’t done them any harm and all this sort of thing. (05; NPT)

Finally, some participants discussed the fact that they were concerned that if they raised the issue of smoking cessation it might damage the relationship that they had with their patients/clients.

I think a major one (difficulty) is if nurses have maybe known the patient for a period of time and (they) feel that it breaks the bond if they … mention smoking. (02; PT)

Efficacy of previous practice

Participants were asked if they believed that their smoking cessation interventions with older people prior to the training had been effective. The majority of the participants were not convinced that their practice had been effective.

No I wouldn’t have said that (I was effective). There is a different way of approaching it and before I did the training I probably wasn’t using the right way to go about it. (02; PT)

Absolutely not (my approach wasn’t effective)! No I did it, I just spurned it out, you know. It was old hat, I’d been doing this for years and smoking was just something that you got nowhere with, or that was my feeling at the time. (08; PT)

Probably not (it wasn’t effective). Several people that I’m thinking about – none of them have managed to stop smoking and my approach was to get them to cut down cigarettes …… that wasn’t effective. (07; NPT)

Only one participant appeared to believe that her/his smoking cessation practice with older people had been effective prior to the training.
You just need to see the hard facts like the amount of people that had stopped in the practice that I work in. (04; PT)

To summarise, the analysis of the participants’ practice prior to the training clearly demonstrates the link between personal factors (i.e. knowledge, attitudes, self-efficacy), environmental factors (e.g. the attitudes of older people) and the participants’ behaviour (i.e. their smoking cessation practice).

For many of the participants’, limited knowledge of smoking cessation in later life and a lack of skills to raise and sustain the subject produced a lack of self-efficacy and outcome expectations that focused on failure. Some participants’ negative attitudes towards older people stopping smoking also affected their subsequent actions and together these factors strongly influenced their smoking cessation practice.

Low self-efficacy causes people to shy away from what they perceive to be difficult tasks (Bandura, 1994). Unless primary care professionals have a) a strong sense of self-efficacy and b) positive outcome expectations for smoking cessation in later life, there is little incentive for them to initiate a discussion or to try to overcome any barriers presented by older patients/clients.

It is evident that the practice of participants who had previous generic smoking cessation training was better than those who had not; however, there were still deficits in knowledge and negative attitudes about smoking cessation in later life were obvious.

b) After the training

Reported practice

The participants were asked to comment on whether they felt that there had been any alteration in their practice since undertaking the training. All eight participants stated that their practice had improved. Some of the changes discussed related to raising the issue of smoking/smoking cessation:

I am certainly more confident in raising (the issue) …. Before I might have been kind of holding back, but there were actually wee tips and kind of guides in how to approach it, just the brief intervention side of it. It actually gives me a wee kind of boost mentioning it (after the training), rather than kind of mention it but kind of feeling in the pit of your stomach … this isn't going to work. I actually got more confident. I think that comes over as well (to clients/patients). (02; PT)

Definitely (there has been an improvement in my practice). I will bring it up at my assessment visit as I always did because I just needed to know who smokes. But I will move it on slightly to a level, you know, to say “Stopping smoking is of far more benefit to your health and there are ways we can help you.” I will raise this and I am far more likely to raise it on subsequent visits as well. (01; NPT)

I certainly discuss it more, so if I bring smoking up and they say they smoked, then I would definitely go into more detail. “Why, you know, why do you think you still smoke, or have you tried to give up before, have you thought about giving up recently, those sorts of things," whereas, I wouldn’t really have gone into any detail (before the training). (05; NPT)
Participants also discussed the enhanced level of information and advice that they were able to provide for patients/clients following the training.

Yes I would say definitely (my practice has changed). I am much more likely to pursue the subject, but hopefully not in a threatening way, using these open questions and a bit of humour and throwing in some of these statistics which I really think do get to people. Sometimes the health ones (impact of smoking/smoking cessation in later life) but more often the amount of money they could save. (07; NPT)

I think my approach has been different and more varied .... I listened (during the training) to other people and how they approach it .... (Since the training), I have been more enthusiastic and asked more questions about how they felt about their smoking. (06: PT).

Since (the training) I have got leaflets and things … so that I’ve got a few in my bag … (And) I have changed my practice and I will definitely now record in my notes if I’ve mentioned it. (01; NPT)

The participants were also more likely to refer older people for group support or to the pharmacy service following the training.

After the training I probably would say “Why don’t you let me refer you?” and try to make that move for them – without being pushy … you can say “Well you know there are these things available, you can go to the pharmacy, if you don’t like the groups, go to the pharmacy.” (02; PT)

I just explain the benefits (of attending groups), you know, more people tend to stop longer term, you know by going to (the groups). I’ll say to them “You’re not told to stop smoking immediately, nobody’s going to lecture (you), they are there to help you. You choose when you want to stop, you know, you pick a date” .... And then I'll explain the pharmacy as well. (03; NPT).

I have a good relationship with the (smoking cessation co-ordinator) and I lift the phone and say I've got somebody here who's really keen to stop smoking .... And that’s been very helpful ... Absolutely invaluable ... You are not pushing somebody, you’re letting them take control. (PT; 06)

While the majority of the participants appeared to have made quite significant changes to their practice, in two instances, while improvements were evident, they were less obvious.

Factors that influenced practice following the training

Factors that appeared to have influenced practice were related to increased knowledge, more positive attitudes towards smoking cessation in later life and the development of skills that helped the participants to raise the issue of smoking/smoking cessation more effectively than previously. This resulted in increased levels of confidence/self-efficacy.

The excerpts below highlight issues relating to enhanced knowledge levels following the training.

My awareness was raised at the training, em because I am (now) very aware of the health implications of smoking (in later life) ... it was raised at the training and the way to get round the negativity (in older people) was highlighted to me. (01; NPT)
I think even just knowing that a lot of older people do actually in fact give up and that encourages other older people ... I think it does give people, kind of hope. (05; NPT)

I would say the figures definitely. I didn’t know about the prevalence and rates and all that sort of thing ... I actually give them figures and I’m quite positive about it and say “It’s never too late (to stop smoking).” (08; PT)

It has been very helpful to be able to give people actual statistics and especially the knowledge that even older people stopping who have smoked for years, that it does have an immediate effect on their health. That has been really helpful to be able to say that with conviction. (07; NPT)

Increased knowledge was closely linked to enhanced confidence and this impacted on the participants’ ability to discuss smoking/smoking cessation with older people.

Since doing the training I feel more confident that I can bring it up, that I can talk to them about brief intervention, I can broach the subject much more easily and I’m not embarrassed to broach the subject and talk about it. I’ve got more knowledge. (01; NPT)

I think just knowing more .... has made me more confident in being able to speak about it because I know more about it now. If people ask me questions then I can answer them or at least come back to them on it. (05; NPT)

Assessing tobacco use and the readiness to quit ... it did make me look at the way I was approaching it and the way I was interpreting what was coming back to me (from conversations with patients/clients) (06; PT)

The participants also indicated that there had been positive changes in their attitudes to smoking cessation in later life as a direct result of information obtained during the training. This had contributed to changes in their practice. Before the training several participants believed older people would find it too difficult to stop smoking and as a result they were reluctant to pursue the subject. Following the training the participants were aware that older people could be successful in stopping smoking and, consequently, improve their health and quality of life.

I just presumed, as I said, that they wouldn’t give up, they just wouldn’t give up and then the training obviously highlighted that people do give up and the reasons why they give up as well. (05; NPT)

It made me feel more positive about – although I wouldn’t say I neglected it but I perhaps wasn’t as enthusiastic ..... So yeah, it reactivated all that for me and made me feel a bit more driven, if you want, to engage them into thinking about it more. (06; PT)

I think the training day helped change my attitude and thinking about what was said then and especially the positive effects that (smoking cessation interventions) have been shown to have on older people stopping smoking, so really it is worthwhile trying to encourage them. (07; NPT)

Just the fact that it is effective giving them this advice. I mean honestly the way I felt before was “Och it’s too late why bother giving up at that time.” So that changed my attitude. Completely, 100%.” (08; PT)
Some participants had previously identified the negative reactions of older people which often acted as barriers to smoking cessation interventions. The following comments demonstrated not just increased confidence but a sense of determination in helping older people who continue to smoke. The important blend of knowledge, attitudes and skills-development is evident.

(“Helping them to understand) that tobacco is not good for their health, you know like that “Och I’ve smoked all my days” and “Och Jimmy up the road smoked till he was 90” or “He didn’t smoke and he died of cancer” and all this kind of stuff. Em it was actually quite good in how to deal with that and how to work your way round that. (02; PT)

They feel as if they’ve been smoking all these years and it’s the young people nowadays that are smoking heroin that are dying and here they’re still living you know. But it’s quite good to say to them that this is more addictive than heroin. (04; PT)

The thing I use mostly from the training, one of the things they told us was the more times you (try to) give up, the more likely you are to succeed … quite a lot of older people have obviously tried to give up quite a lot of times, so em you know if you tell them that, that’s some encouragement for them to try again. (05; NPT)

While the referral of clients for group and pharmacy support had increased following the training, a point raised was that a number of the patients/clients that the participants were visiting were either housebound or had disabilities that limited their ability to attend group and pharmacy services. This meant that the level of referral for some participants was still quite limited.

The problem is … the huge majority of people that I see are housebound so they can’t go to (services like) the chemist … (Also) quite a few of the clients I see find it quite difficult to use the telephone … so it’s not even that they can phone Smokeline for extra support … So its quite difficult for them to access support with the services that are available at the moment. (05; NPT)

The issue of the willingness of older people to travel to specialist services was also raised.

A lot of it is accessibility as well for the group sessions, you know they’re not willing to travel anywhere. (03; NPT)

6.4 Summary

The analysis of the participants’ practice after the training once again demonstrates the interaction between personal factors (e.g. knowledge, attitudes, self-efficacy), environmental factors (e.g. attendance at the smoking cessation training) and the participants smoking cessation practice (i.e. their behaviour).

The analysis has shown that the smoking cessation practice of the eight participants changed positively compared to their practice before the training. It has also highlighted the essential role of self-efficacy in facilitating behaviour change.

The words of one participant, who had undertaken generic training previously appeared to sum up the added value of the tailored training:

Basically, you assume that you know all these things but you don’t actually until you go on a course like that, you actually find a whole lot of new things that you can try (with older people). (02; PT)
7. Discussion/conclusion

7.1 Introduction

The aim of the study was to develop and test the impact of specially tailored smoking cessation training for members of the primary care team who have contact with older adults.

7.2 Summary/discussion of the results

Following its development, the impact of the training was assessed using a mixed methods approach. The quantitative evaluation of the training took the form of a randomised-controlled trial, with a pre-test post-test experimental design being adopted.

The quantitative assessment of the training demonstrated the following:

- A statistically significant improvement in the knowledge of the intervention group that was maintained over time.
- A statistically significant improvement in the therapeutic attitudes of the intervention group that was maintained over time.
- A statistically significant improvement in reported practice of the intervention group that was maintained over time.

The training was therefore found to be effective i.e. it had a demonstrable positive impact on the knowledge, attitudes and practice of the study participants.

The qualitative evaluation of the training confirmed what had been shown by the quantitative results. Prior to the training, members of the intervention group reported limited knowledge and a lack of skills to raise and sustain the subject of smoking/smoking cessation. This often produced a lack of self-efficacy and outcome expectations that focused on failure. Participants’ negative attitudes towards older people stopping smoking also affected their subsequent actions and together these factors strongly influenced their smoking cessation practice. It was evident that the practice of participants who had previous generic smoking cessation training was at a more advanced level than those who had not; however, there were still deficits in knowledge and pessimistic attitudes towards smoking cessation in later life were reported.

The analysis of the participants’ practice after the training clearly demonstrated changes in their practice. These changes were reported as a result of increased knowledge levels, more positive attitudes towards smoking cessation in later life and the skills that had been developed during the training. Enhanced levels of self-efficacy following the training were clearly evident.

As discussed previously, healthcare contacts provide excellent opportunities for smoking cessation interventions. As older adults are known to have frequent contacts with members of the primary care team, these professionals have a crucial role to play in the delivery of brief smoking cessation interventions. While the important role of the primary care team has been highlighted, previous research has demonstrated the need to develop their knowledge and skills to enable them to deliver effective brief interventions (Kerr et al 2004). The key role of therapeutic attitudes has also been noted, with key policy documents highlighting the fact that the willingness of professionals to interact with patients/clients is an important predictor of effective engagement (Scottish Executive 2002).
7.3 The rigour of the study

A key issue when designing and undertaking the study was to ensure that the end result would be a viable and rigorous piece of work. The determinants of rigour in quantitative research are reliability and validity. The design of studies to evaluate interventions is important and the randomised controlled trial is recognised as the gold standard (Polit 2006). The use of a control group is an essential element of a randomised controlled trial as it helps to eliminate the possibility that extraneous variables (i.e. variables other than the intervention), were responsible for any differences between the scores of the groups. The use of standardised, reliable and valid instruments was also essential to ensure the internal validity of the results. Finally, the fact that the sample was selected from a cohort of nurses and allied health professionals in seven Community Health and Care Partnerships contributed to the potential generalisability of the results.

Efforts were also made to ensure the rigour of the qualitative element of the study. As recommended by Beck (1993), strategies adopted to enhance the credibility of the findings included the audio-recording of the interviews, peer-review of the data analysis process and the inclusion of excerpts from the transcripts when presenting the findings.

When selecting a sample in a qualitative study, and when aiming to enhance the transferability of the findings, efforts should be made to ensure diversity in the sample (Lincoln & Guba 1985). Analysis of the demographic characteristics and the quantitative scores of the eight professionals who participated in the qualitative element of the study, suggest that there was diversity in the sample (i.e. moderate to large changes in the quantitative scores were evident).

Finally, strategies adopted to enhance the auditability of the findings include the provision of a detailed description of the methods used to recruit the sample; presentation of the instrument used to collect the data (see Appendix 23); the recording and transcription of the interviews; a description of the procedures used to analyse the data (including peer review); and, the use of participants accounts (i.e. quotes) to substantiate the topics/areas discussed in the findings.

7.4 Limitations of the study

A potential limitation of the study is the fact that the response rate was low. While a total of 783 nurses, allied health professionals and social workers were invited to participate in the quantitative element of the study, the actual number of participants was 73 (falling to 52 at the end of the study). When response rates are low the researchers must consider whether the study participants were likely to be similar or different to those who did not participate. In this instance, for example, the professionals who participated in the study were less likely to be smokers than those who did not i.e. <3% of the participants were smokers while c.20% of community nurses are known to smoke (McKenna et al 2001). A low response rate therefore has the potential to limit the generalisability of the results.

Another potential limitation is that what is discussed in terms of practice; is ‘reported practice’ i.e. the participants views of their practice following the training. Within the confines of this particular study, there is no way of measuring the accuracy of participants’ accounts of their own practice.

7.5 Conclusion

In conclusion, this study has developed and tested the impact of specially tailored smoking cessation training for professionals who have contact with older adults. The training was found to have a positive impact on the knowledge, attitudes and practice of
the professionals who undertook the training. Previous research has demonstrated that the delivery of brief opportunistic interventions by health professionals is something that is very cost effective (NHS Health Scotland/ASH Scotland).

While generic smoking cessation training has been delivered for a number of years, the need to develop tailored training for professionals who have contact with key priority groups, including older adults, has been identified more recently (PATH/ASH Scotland 2003a,b). We believe that we are the first group at a UK-wide level to develop and formally test the efficacy of tailored smoking cessation training for professionals who have contact with older adults. We therefore consider that this study makes an important contribution to the current evidence base.

8. Recommendations

Recommendations are made for future research, practice and education

8.1 Research

In light of the study’s positive results, we recommend that the training be rolled out throughout Scotland. Future delivery and evaluation of the training would benefit from efforts to measure the practice of the study participants following the training more objectively (what is discussed in this study was reported practice). It is therefore recommended that future work also makes use of more objective measures such as practice diaries and/or non-participant observation.

One important issue that was highlighted during the qualitative interviews was that many of the older clients visited by the participants were housebound or had disabilities that limited their capacity to attend smoking cessation groups or the pharmacy ‘Stop Smoking’ service. This meant that the professionals who participated in the study could not follow current evidence based guidelines which recommend that they refer clients/patients who indicate that they would like to make a cessation attempt to specialist services for support. The lack of intensive support for people who are housebound has been highlighted previously (Kerr et al 2004) and it is something that NHS Specialist Services in many areas are aware of. While important efforts are being made to provide additional support e.g. through telephone support, we recommend that research is undertaken to develop and test different models of support for people who are housebound, in order to determine which method/s of support are most cost-effective. Our group aims to seek funding to undertake work in this area.

Finally, it has been suggested previously that brief smoking cessation interventions can be delivered by people who are not health professionals. As older people have contact with a variety of workers such as home helps and care wardens (in sheltered housing complexes) it is recommended that future work tests the cost-effectiveness of brief interventions delivered by people other than health professionals. Again, this is an area that we would like to explore in future work.

8.2 Practice

It is recommended that tailored brief intervention training be available for all members of the primary care team who have contact with older adults. Current evidence suggests that at present professionals do not have the knowledge and skills required to deliver effective smoking cessation interventions.
8.3 Education

Finally, we recommend that tailored smoking cessation training be incorporated into educational programmes for professionals who will have high levels of contact with older adults.

9. Dissemination

The Research Team plans to disseminate the study results at local, national levels and international levels.

9.1 Executive summaries

An Executive Summary will be forwarded to the following people/organisations:

- Commissioners of training in each NHS Health Board Area in Scotland
- ASH Scotland’s Training & Development Team
- NHS Health Scotland
- Smoking Concerns
- Age Concern
- Help the Aged
- Scottish Tobacco Control Alliance (STCA)
- Action on Smoking and Health (Scotland, England, Wales and Northern Ireland)
- Directors of Nursing (Primary Care) – NHS Boards throughout Scotland
- Higher Education Institutions delivering Community Programmes (Scotland)
- Scottish Executive
- Quality Improvement Scotland (QIS)
- NHS Education Scotland (NES)
- The study participants

Full copies of the report will be provided, on request, from Susan Kerr at the following e.mail address: s.m.kerr@gcal.ac.uk. It is also anticipated that the report will be available on the ASH Scotland web-site.

9.2 Conference papers

The following papers have been presented:


A paper has also been accepted for the Scottish Smoking Cessation Conference which will be held in Glasgow in December 2007.

Other opportunities to disseminate the findings orally will be sought, as appropriate.

9.3 Peer reviewed/professional journals

The Research Team will also prepare a number of papers for publication in both peer-reviewed and professional journals.
References


APPENDIX 1 – LEARNING OUTCOMES SMOKING CESSATION TRAINING

By the end of the training participants will be able to:

Rationale for Brief Advice
- Explain the meaning and purpose of brief advice to stop smoking in the older adult population.
- Describe the role of brief interventions in local and national service provision and practice
- Have knowledge of local and national prevalence rates and cessation targets
- Have an awareness of the cost effectiveness of brief advice and other smoking cessation interventions

Smoking and Health
- Give an account of the negative effects of smoking on health in relation to older adults, and be able to personalise this information to individual clients.
- Have an awareness of smoking and health inequalities with regard to older adults
- Describe the main features of nicotine withdrawal symptoms.
- Explain the risks associated with passive smoking and the impact of environmental tobacco smoke (ETS) on children and adults.

Assessing a Client's Tobacco Use
- Understand the social and behavioural aspects of smoking and the nature of nicotine addiction.
- Demonstrate the use of open-ended questions in eliciting appropriate responses in relation to smoking status and readiness to quit

Prompting and supporting a Quit Attempt
- Explain the benefits of stopping smoking in later life
- Dispel common myths about perceived benefits of smoking
- Describe compensatory smoking in relation to cutting down or switching to low tar brands
- Understand the barriers to making a quit attempt
- Describe behavioural support and pharmacological therapies that can support a quit attempt and their rates of effectiveness

Communication skills
- Develop communication techniques in raising the issue of smoking/tobacco use appropriately with their clients

Local Specialist Smoking Cessation Services
- Describe the provision of local Smoking Cessation Services and how a client can access them and how a referral to them can be made.
- Be aware of how to access information on Smoking Cessation issues and know whom to contact for information at local level.

Resources
- Be aware of resources available that can support brief intervention and smoking cessation and know how to access them
- Know where to access professional help and support to keep up to date with research/best practice in relation to smoking cessation and tobacco issues

Recording, Monitoring and Data collection
- Be aware of local practice and national guidelines relating to monitoring and evaluation.
### APPENDIX 2 – KNOWLEDGE QUESTIONNAIRE PSYCHOMETRIC TESTING

Please draw on your current knowledge when answering the questions below.

<table>
<thead>
<tr>
<th>1) Approximately what percentage of people currently smoke in Scotland (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% ☐</td>
</tr>
<tr>
<td>25% ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2) Approximately what percentage of people aged 65-74 years currently smoke in Scotland (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% ☐</td>
</tr>
<tr>
<td>25% ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3) Approximately what percentage of people aged 75+ years currently smoke in Scotland (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% ☐</td>
</tr>
<tr>
<td>25% ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) How many years, on average, do people who smoke regularly and die from a smoking-related disease lose from their life expectancy compared with a non-smoker (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 yrs ☐</td>
</tr>
<tr>
<td>10 yrs ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5) Which of the following statements are true and which are false in relation to older people (65+ years) who smoke? If you don’t know the answer please tick ‘Don’t know’.</th>
</tr>
</thead>
</table>
| a) Older people who smoke have an increased risk of developing lung cancer when compared with non-smokers of the same age.  
True ☐  False ☐  Don’t know ☐ |
| b) Smoking can reduce the effectiveness of some drugs prescribed for conditions that are common in later life (e.g. arthritis, heart disease, hypertension).  
True ☐  False ☐  Don’t know ☐ |
| c) Smoking can cause serious complications in older people who have diabetes.  
True ☐  False ☐  Don’t know ☐ |
| d) Smoking is associated with an increased risk of developing bladder cancer in later life.  
True ☐  False ☐  Don’t know ☐ |
| e) Smoking can delay wound healing in older people.  
True ☐  False ☐  Don’t know ☐ |
| f) Smoking is associated with an increased risk of developing ischaemic heart disease in later life.  
True ☐  False ☐  Don’t know ☐ |
| g) Smoking is associated with an increased risk of developing Parkinson’s Disease in later life.  
True ☐  False ☐  Don’t know ☐ |
| h) The risk of an older person having a heart attack or stroke decreases within 24 hours of stopping smoking.  
True ☐  False ☐  Don’t know ☐ |
<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Stopping smoking does not generally stop the progression of chronic obstructive pulmonary disease (COPD).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) There is currently no evidence to suggest that chewing tobacco is harmful to health.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Brief smoking cessation advice* is as effective as more intensive advice** in helping older people to stop smoking.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) It is not clear whether nicotine replacement therapy is effective in helping people to stop smoking.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) The National Evaluation of Smoking Cessation Services in England found that younger people attending specialist services are more likely to stop smoking than older people.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n) Smoking cessation support for older people can be provided by staff working in pharmacies in Glasgow.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o) Smoking cessation group support is currently provided in all of the Community Health and Social Care Partnerships in the Greater Glasgow area.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p) Older people who smoke can self-refer to smoking cessation group support sessions in the Greater Glasgow area.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q) Generally speaking, people with stable ischaemic heart disease can use nicotine replacement therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r) It is not generally recommended that Bupropion (Zyban) be used in later life to support a smoking cessation attempt.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s) Less than 5% of older smokers say that they would like to stop smoking.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t) The Smoking Cessation Guidelines for Scotland suggest that the role of members of the primary care team is to ‘trigger’ rather than ‘support’ a smoking cessation attempt in later life.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>u) There is currently no dedicated Helpline in Scotland for people who wish to stop smoking.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Brief smoking cessation advice involves opportunistic advice to smokers to stop smoking. Advice normally takes less than 3 minutes.

**Intensive advice can be carried out on a one to one or group basis. It involves face to face support of smokers during a quit attempt.
APPENDIX 3 – THERAPEUTIC ATTITUDES QUESTIONNAIRE PSYCHOMETRIC TESTING

Please indicate the extent of your agreement or disagreement with each of the following statements about working with older people (≥ 65 years) who smoke.

<table>
<thead>
<tr>
<th>Please circle one number for each question</th>
<th>Strongly agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I feel that I understand what causes older people to continue to smoke.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>2) I feel that I have sufficient knowledge of the detrimental effects of smoking in later life to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>3) I feel that I have sufficient knowledge of the benefits of stopping smoking in later life to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4) I feel that I have sufficient knowledge of the barriers that may prevent older people from attempting to stop smoking.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>5) I feel that I have sufficient knowledge of nicotine addiction/withdrawal to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>6) I feel that I have sufficient knowledge of the factors that might encourage older people to stop smoking.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>7) I feel that I have the skills required to encourage older smokers to attempt to stop smoking.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>8) I feel that I have sufficient knowledge of pharmacological agents that can assist a cessation attempt (e.g. nicotine replacement therapy) to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>9) I feel that I have sufficient knowledge of specialist smoking cessation services to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>10) I feel that health and social care staff who smoke may not be able to effectively encourage older people to attempt to stop smoking.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>11) I feel that I have a clear idea of my responsibilities in helping older people to stop smoking.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>12) I feel that I have the right to ask older smokers questions about their tobacco use.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>13) I feel that the older smokers I have contact with believe that I have the right to ask questions about their tobacco use.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>14) I feel that discussing smoking cessation with older smokers is an important part of my role as a health/social care professional.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>15) I feel that it not fair to encourage older people to stop smoking as it is one of the few pleasures that they have in life.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>
16) I feel that health and social care staff should always weigh the potential psychological harm of a cessation attempt against the potential physical benefits of stopping smoking.

17) If I felt the need when working with an older smoker I could easily find someone with whom I could discuss any personal difficulties that I might encounter.

18) If I felt the need when working with an older smoker I could easily find someone who would help me clarify my professional responsibilities (e.g. in relation to accountability, clinical governance issues).

19) If I felt the need I could easily find someone who would help me formulate the best approach to encouraging an older person to stop smoking.

20) I feel that it is the role of more specialist staff to actually support a cessation attempt.

21) I am interested in what can be done to encourage older people to stop smoking.

22) I enjoy the challenge of encouraging older people to stop smoking.

23) I feel that the best I can personally offer older smokers is referral to somebody else, rather than attempting to encourage them to stop smoking myself initially.

24) I feel that there is little I can do to help older people who smoke to stop.

25) Pessimism is the most realistic attitude to take towards the possibility that older smokers might manage to stop smoking successfully.

26) I feel I am able to encourage older people to stop smoking as effectively as my colleagues.

27) In general, I feel that I am a failure when it comes to providing effective encouragement to older smokers to stop smoking.

28) On the whole, I am happy that I encourage older people to stop smoking in an effective manner.

29) I often feel uncomfortable when asking older people about their smoking.

30) In general, I am satisfied with my own ability to discuss the subject of smoking and smoking cessation with the older people I have contact with.
## APPENDIX 4 – PRACTICE QUESTIONNAIRE PSYCHOMETRIC TESTING

Please tick the appropriate box, focusing on your practice last week (if last week was unusual think of a typical week at work):

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Often</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) How often did you ask the older people (65+ years) you had contact</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>with about their smoking status (i.e. whether they are a smoker/former</td>
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<tr>
<td>smoker and/or how many cigarettes they smoke on a daily basis)?</td>
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<tr>
<td>2) How often did you raise the topic of smoking cessation with the older</td>
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</tr>
<tr>
<td>smokers you had contact with?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3) How often did you assess older smokers’ readiness to stop smoking?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) How often did you discuss the benefits of stopping smoking with the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>older smokers you had contact with?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) How often did you encourage older smokers to think about stopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>smoking?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6) How often did you discuss the success rate of smoking cessation in</td>
<td></td>
<td></td>
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<tr>
<td>later life with people whom you thought might attempt to stop at some</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>point in the future?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7) How often did you discuss the use of Nicotine Replacement Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Zyban with people whom you thought might attempt to stop smoking at</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>some point in the future?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) How often did you discuss specialist smoking cessation services (e.g.</td>
<td></td>
<td></td>
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<tr>
<td>group support) or the Glasgow Pharmacy Service with people whom you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>thought may attempt to stop smoking some point in the future?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) How often did you document an older smokers’ smoking status in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>their case notes?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) How often did you document the details of any conversations that</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>you had with an older smoker about smoking/smoking cessation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered ‘Rarely’ or ‘Never’ to any of the above questions, it will be very useful if you can provide some information on factors that may have influenced your practice when you had contact with older people (65+ years) who smoke. Please read the statements below and tick all that are appropriate:

- I do not generally have time to discuss smoking/smoking cessation.
- I do not think that it is part of my role to discuss smoking/smoking cessation.
- I did not ask the older people I had contact with about their smoking status as I already had this information.
- I did not assess the older smokers’ readiness to stop smoking as I already know their views on stopping smoking.
- I think that there is little to be gained by stopping smoking in later life.
- Smoking is the only pleasure that many older people have in life.
- I think that it is unfair to ask an older person to stop smoking.
- I am concerned that mentioning smoking will damage the relationship that I have with the older smokers I have contact with.
- A number of the older people I have contact with have a terminal illness or a mental health problem (e.g. depression) and I do not feel that it is appropriate to broach the subject of stopping smoking in these circumstances.
- Other (please provide details) ____________________________________________
APPENDIX 5a – UNIVERSITY ETHICS APPROVAL

PMeQ/LM/A05/03

20th October 2005

Dr Susan Kerr
NMCH Research Centre
Glasgow Caledonian University
Cowcaddens Road
Glasgow
G4 0BA

Dear Dr Kerr

Smoking cessation in later life (>65 years): a study to test the psychometric properties of three instruments designed to measure the knowledge, attitudes and practice of health professionals.

The School Research Ethics Committee has completed its scrutiny of your application for ethical approval for the above study.

I am pleased to inform you that ethical approval has been granted. The committee note that you intend to dispose the tapes and transcripts at end of study.

The scrutinisers queries whether the exclusion criteria should be developed to avoid participants in this study being involved in the substantive study.

I wish you well in your study

Yours sincerely

Paddy McQuillan
Chair
School Research Ethics Committee

CALEDONIAN UNIVERSITY

WHO COLLABORATING CENTRE FOR NURSING AND MIDWIVES

City Campus
Cowcaddens Road
Glasgow G4 0BA
Telephone: 0141 331 8311
Facsimile: 0141 331 8312
E-Mail R.A.Patton@caledonian.ac.uk
Website www.caledonian.ac.uk

Principal and Vice-Chancellor
Dr Ian Johnston

42
From: Brodie, Ian  
Sent: 17 November 2005 12:15  
To: Kerr, Susan  
Subject: Smoking cessation research project  

Susan,

To confirm that the "Smoking cessation" project has been approved by the HSC Ethics Committe.

Thanks for sending p'work.

We've coded the project "EC05/10" for our Ethics decisions table, in case you need to quote this!

With good wishes for the project,

Ian  

(Chair, HSC Ethics)
APPENDIX 6 - INFORMATION SHEET PSYCHOMETRIC TESTING

Title of the study

Smoking cessation in later life: a study to test the reliability and validity of three questionnaires.

What is the study about?

You are being asked to take part in a small scale study that will assess the reliability and validity of three questionnaires that have been developed for a study that will be undertaken early next year. The aim of the main study is to test whether the delivery of specially tailored smoking cessation training will impact on the knowledge and attitudes of health professionals who have contact with older people who smoke. We are also interested to see whether the smoking cessation training affects the health professionals' practice in any way (e.g. encouraging them to discuss the topic of smoking cessation more often with older adults).

Why have you been asked to help with the study?

You have been asked to help with the study because you will have some contact with older people (65+ years) who smoke in your role as a student or qualified nurse. As it is very likely you will have had this type of contact you should be able to answer the questions, based on your experience. You have been approached along with approximately 500 other people who are currently registered students in the School of Nursing, Midwifery & Community Health.

Who is carrying out the study?

The study is being carried out by a team of researchers based in the [name taken out]. We are all experienced nurses who have worked in primary, secondary and continuing care settings. The Research Team is led by Susan Kerr and the other researchers are Hazel Watson, Rosemary Whyte and Debbie Tolson. When undertaking the study we are working with Angus McFadyen who is a statistician.

The study is funded by ASH Scotland and the Glasgow Health City Partnership.

If you agree to help, what will you be asked to do?

If you agree to help with the study you will be asked to complete three questionnaires. One of the questionnaires focuses on 'knowledge' of issues relating to smoking cessation in later life, one looks at 'attitudes' towards smoking cessation in later life and the other looks at 'practice'. You will be asked to complete the three questionnaires today, which should take between 10 and 15 minutes. We are undertaking a number of tests that are linked to reliability and validity. One of the tests involves what is called 'test-retest reliability'. Because we are undertaking this test we will also ask you to complete the three questionnaires again in 2 weeks time.
What should you do if you would like to take part?

If you are happy to take part in the study you should complete the three questionnaires and place them in the sealed box at the front of the classroom. As discussed, you will be asked to complete the same questionnaires again in 2 weeks time. It is important that we are able to compare your answers at the two separate times and so we are asking you to provide some information that is unique to yourself. You will see that on the front page of the questionnaires you are asked to provide details of your date of birth and your house number (e.g. 30/12/59:92). This is to help us match your answers at the two time points. We are asking you to provide this form of information, rather than your name, to ensure that your identity is protected.

If you would like more information about the study before deciding whether to take part please feel free to ask the member of the research team who is distributing the questionnaires today. If you would rather speak to us privately, please contact [name taken out] on Tel. [number taken out] or [e.mail address taken out]. [Name taken out] will be happy to provide more information.

What will happen to the results of the study?

The main reason that we are asking you to complete the questionnaires is to help ensure that we are using questionnaires that are both reliable and valid when we undertake the main study. The results of the full study (including this section where the questionnaires were tested) will be published in a report that will be submitted to the funding bodies (i.e. ASH Scotland and the Glasgow Health City Partnership). We may also publish the results in a journal (e.g. the Journal of Advanced Nursing). You should be reassured that the people who have taken part in the study will not be identified in any way. We are bound by the conditions of the Data Protection Act (1998) and we will therefore ensure that the anonymity of the study participants is protected and that confidentiality is maintained.

What will happen if you don’t take part in the study?

Participation in the study is entirely voluntary. If you do not wish to participate it will not affect your role as a student at the University in any way. Also, please note that if you agree to take part at this point, you are free to change your mind and withdraw at any point.

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION
APPENDIX 7 – KNOWLEDGE QUESTIONNAIRE QUANTITATIVE STUDY

Please draw on your current knowledge when answering the questions below. If you don’t know the answer please tick ‘Don’t know’, rather than guessing.

<table>
<thead>
<tr>
<th>1) Approximately what percentage of people currently smoke in Scotland (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% □ 30% □ Don’t know □</td>
</tr>
<tr>
<td>25% □ 45% □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2) Approximately what percentage of people aged 65-74 years currently smoke in Scotland (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% □ 30% □ Don’t know □</td>
</tr>
<tr>
<td>25% □ 45% □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3) Approximately what percentage of people aged 75+ years currently smoke in Scotland (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% □ 30% □ Don’t know □</td>
</tr>
<tr>
<td>25% □ 45% □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) How many years, on average, do people who smoke regularly and die from a smoking-related disease lose from their life expectancy compared with a non-smoker (please tick one box only)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 yrs □ 15 yrs □ Don’t know □</td>
</tr>
<tr>
<td>10 yrs □ 20 yrs □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5) Which of the following statements are true and which are false in relation to older people (65+ years) who smoke?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Smoking is associated with an increased risk of developing bladder cancer in later life.</td>
</tr>
<tr>
<td>True □ False □ Don’t know □</td>
</tr>
</tbody>
</table>

| b) Smoking is associated with an increased risk of developing Parkinson’s Disease in later life. |
| True □ False □ Don’t know □  |

| c) The risk of an older person having a heart attack or stroke decreases within 24 hours of stopping smoking. |
| True □ False □ Don’t know □  |

| d) Stopping smoking does not generally stop the progression of chronic obstructive pulmonary disease (COPD). |
| True □ False □ Don’t know □  |

| e) There is currently no evidence to suggest that chewing tobacco is harmful to health. |
| True □ False □ Don’t know □  |

<p>| f) Brief opportunistic smoking cessation interventions delivered by health professionals have not been shown to be cost-effective in encouraging an attempt to stop smoking. |
| True □ False □ Don’t know □  |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>g)</strong> It is still not clear whether nicotine replacement therapy is effective in helping people to stop smoking.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>h)</strong> The National Evaluation of Smoking Cessation Services in England found that younger people attending specialist services are more likely to stop smoking than older people.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>i)</strong> Smoking cessation group support is currently provided in all of the Community Health and Care Partnerships (CHCPs) in NHS Greater Glasgow &amp; Clyde.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>j)</strong> Older people who smoke can self-refer to smoking cessation group support sessions in the Greater Glasgow &amp; Clyde area.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>k)</strong> Generally speaking, people with stable ischaemic heart disease can use nicotine replacement therapy safely.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>l)</strong> It is not generally recommended that Bupropion (Zyban) be used in later life to support a smoking cessation attempt.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>m)</strong> Less than 5% of older smokers say that they would like to stop smoking.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>n)</strong> The Smoking Cessation Guidelines for Scotland suggest that the role of members of the primary care team is to ‘trigger’ rather than ‘support’ a smoking cessation attempt in later life.</td>
<td>True</td>
<td>False</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>
Please indicate the extent of your agreement or disagreement with each of the following statements about working with older people (65+ years) who smoke.

<table>
<thead>
<tr>
<th>Please circle one number for each question</th>
<th>Strongly Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I feel that I understand what causes older people to continue to smoke.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>2) I feel that I have sufficient knowledge of the detrimental effects of smoking in later life to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>3) I feel that I have sufficient knowledge of the benefits of stopping smoking in later life to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>4) I feel that I have sufficient knowledge of the barriers that may prevent older people from attempting to stop smoking.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>5) I feel that I have sufficient knowledge of nicotine addiction/withdrawal to be able to discuss this effectively when I have contact with older people who smoke.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>6) I feel that I have sufficient knowledge of the factors that might encourage older people to stop smoking.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>7) I feel that I have the right to ask older smokers questions about their tobacco use.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>8) I feel that the older smokers I have contact with believe that I have the right to ask questions about their tobacco use.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>9) I enjoy the challenge of encouraging older people to stop smoking.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>10) I feel that the best I can personally offer older smokers is referral to somebody else, rather than attempting to ‘trigger’ a cessation attempt myself.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>11) Pessimism is the most realistic attitude to take towards the possibility that older smokers might manage to stop smoking successfully.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
<tr>
<td>12) I feel I am at least as effective as my colleagues in encouraging older people to stop smoking.</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
</tr>
</tbody>
</table>
Please tick the appropriate box, focusing on your practice last week (if last week was unusual think of a typical week at work)

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Often</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) How often did you ask the older people (65+ years) you had contact with about their smoking status (i.e. whether they are a smoker/former smoker and/or how many cigarettes they smoke on a daily basis)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) How often did you raise the topic of smoking cessation with the older smokers you had contact with?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) How often did you discuss older smokers’ readiness to stop smoking?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) How often did you encourage older smokers to think about stopping smoking?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) How often did you discuss the success rate of smoking cessation in later life with people whom you thought might attempt to stop at some point in the future?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) How often did you discuss the use of Nicotine Replacement Therapy or Zyban with people whom you thought might attempt to stop smoking at some point in the future?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) How often did you discuss specialist smoking cessation services (e.g. group support) or the Glasgow Pharmacy Service with people whom you thought may attempt to stop smoking at some point in the future?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) How often did you refer the older smokers you had contact with to specialist smoking cessation services or the Glasgow Pharmacy Service?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) How often did you record an older smoker’s smoking status?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) How often did you record the details of any conversations that you had with an older smoker about smoking/smoking cessation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continues on next page/
If you answered ‘Rarely’ or ‘Never’ to any of the above questions, it will be very useful if you can provide some information on factors that may have influenced your practice when you had contact with older people (65+ years) who smoke. Please read the statements below and tick all that are appropriate:

a) I do not generally have time to discuss smoking/smoking cessation.  

b) I do not think that it is part of my role to discuss smoking/smoking cessation.  

c) I did not ask the older people I had contact with about their smoking status as I already had this information.  

d) I did not assess the older smokers’ readiness to stop smoking as I already know their views on stopping smoking.  

e) I think that there is little to be gained by stopping smoking in later life.  

f) I think that it is unfair to ask an older person to stop smoking.  

g) Smoking is the only pleasure that many older people have in life.  

h) I am concerned that mentioning smoking will damage the relationship that I have with the older smokers I have contact with.  

i) A number of the older people I have contact with have a terminal illness or a mental health problem (e.g. depression) and I do not feel that it is appropriate to broach the subject of stopping smoking in these circumstances.  

j) Other (please provide details)  _____________________________________  

________________________________________________________
APPENDIX 10 – ETHICS APPROVAL QUANTITATIVE STUDY

Primary Care Division

Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
Tel: 0141 211 3600
www.nhsgg.org.uk

Dr Susan Kerr
Senior Research Fellow
School of Nursing, Midwifery & Community Health
Glasgow Caledonian University
Cowcaddens Road
Glasgow
G4 0BA

Date
24 February 2006
Your Ref
Our Ref

Direct line
0141 211 3824
Fax
0141 211 3814
E-mail
anne.mcmahon@gartnavel.
glacomen.scot.nhs.uk

Dear Dr Kerr:

Full title of study: Smoking cessation in later life: an evaluation of the impact of smoking cessation training on the knowledge, attitudes and practice of members of the primary care team who work with older people.

REC reference number: 05/S0701/154

Thank you for your letter of 08 February 2006, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 23 February 2006. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised providing line managers do not provide a list of names and a general mailshot is used.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:
<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>one</td>
<td>20 December 2005</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>SK</td>
<td>20 December 2005</td>
</tr>
<tr>
<td>Protocol</td>
<td>one</td>
<td>18 March 2005</td>
</tr>
<tr>
<td>Compensation Arrangements</td>
<td>letter</td>
<td>20 December 2005</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>knowledge</td>
<td></td>
</tr>
<tr>
<td>Questionnaire</td>
<td>attitudes</td>
<td></td>
</tr>
<tr>
<td>Questionnaire</td>
<td>practice</td>
<td></td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>one</td>
<td>20 December 2005</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>one</td>
<td>20 December 2005</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>one</td>
<td>20 December 2005</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td></td>
<td>08 February 2006</td>
</tr>
<tr>
<td>Other</td>
<td>training sheet</td>
<td>20 December 2005</td>
</tr>
</tbody>
</table>

**Research governance approval**

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

*05/S0701/154* Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project

Yours sincerely

A W McMahon
Research Ethics Co-ordinator (Manager) on behalf of Dr Paul Fleming, Chair

Email: Anne.McMahon@gartnavel.glaomen.scot.nhs.uk

**Enclosures:** List of names and professions of members who were present at the meeting and those who submitted written comments

Standard approval conditions

Site approval form

**Copy to:**

Glasgow Caledonian University
Cowcaddens Road
Glasgow
R&D Department for NHS care organisation at lead site
APPENDIX 11 – ETHICS APPROVAL QUALITATIVE STUDY

Primary Care Division

Dr Susan Kerr
Senior Research Fellow
Glasgow Caledonian University
Cowcaddens Road
Glasgow
G4 0BA

Date: 24 November 2006
Your Ref: Your Ref
Our Ref: Our Ref
Direct line: 0141 211 3824
Fax: 0141 211 3814
E-mail: Liz.Jamieson@gartnavel
        glacomenc.scot.nhs.uk

Dear Dr Kerr,

Study title: Smoking cessation in later life: an evaluation of the impact of smoking cessation training on the knowledge, attitudes and practice of members of the primary care team who work with older people.

REC reference: 05/S0701/154

Amendment number: Two
Amendment date: 20 November 2006

The above amendment was reviewed at the meeting of the Chair’s Actions held on 24 November 2006.

Ethical opinion

The Chair gave a favourable ethical opinion of the amendment on the basis described in your letter dated 20th November 2006.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter dated 20th November 2006</td>
<td></td>
<td>20 November 2006</td>
</tr>
</tbody>
</table>

Research governance approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/S0701/154  Please quote this number on all correspondence

Yours sincerely

Mrs Liz Jamieson
Committee Co-ordinator

Copy to:  R&D Department for NHS care organisation at lead site
Dear Dr Kerr

Project Reference Number: 05CH83
Project Title: Smoking Cessation in Later Life: An Evaluation of the Impact of Smoking Cessation Training on the Knowledge, Attitudes and Practice of Members of the Primary Care Team who Work with Older People

Thank you for completing the Research & Development (R&D) Management Approval Application for the above study. I am pleased to inform you that R&D management approval has been granted by Greater Glasgow Primary Care Division subject to the following requirements:

- You should notify me of any changes to the original submission and send regular, brief, interim reports including recruitment numbers where applicable.

- Your research must be conducted in accordance with the National Research Governance standards. (see CSO website: www.show.scot.nhs.uk/cs)
  Local Research Governance monitoring requirements are presently being developed. This may involve audit of your research at some time in the future.

- You must comply with any regulations regarding data handling (Data Protection Act).

- Brief details of your study will be entered on the National Research Register (NRR). You will be notified prior to the next submission date and asked to check the details being submitted.

- A final report, with an abstract which can be disseminated widely within the NHS, should be submitted when the project has been completed.

Do not hesitate to contact the R & D office if you need any assistance.

Thank you again for your co-operation.

Yours sincerely

Brian Rae
Research Manager
Dear Dr. Kerr,

Smoking cessation in later life: an evaluation of the impact of smoking cessation training on the knowledge, attitudes and practice of members of the primary care team who work with older people 05CH63

Amendment dated 25 May 2006

The R&D Office has recently been informed of the amendment to the above study.

I am pleased to inform you that the amendment does not affect the original decision to grant R&D Management Approval.

Yours sincerely,

Brian Rae
Research Manager
Dear Colleague,

**Study title: An evaluation of the impact of tailored smoking cessation training for members of the primary care team who have contact with older people (65+ years) who smoke.**

I am writing to invite you to take part in a study that will evaluate the impact of smoking cessation training specially tailored for district nurses, health visitors, practice nurses, allied health professionals and social workers who have contact with older people who smoke. The training has been formally approved by NHS Education for Scotland (NES) and the organisation Partnership Action on Tobacco and Health (PATH), which oversees smoking cessation training in Scotland.

As this training is the first of its kind in Scotland, and probably the UK, it is important that it is evaluated to see how useful it is for health and social care professionals like yourself. As you will know, research evidence should underpin professional practice, and participation in the study is an opportunity for you to be involved in the development of the evidence base for smoking cessation training in Scotland.

I have enclosed an Information Sheet that provides details of the study and what your participation would involve. If after reading the information you would like to take part in the study, please complete and return the Consent Form in the envelope provided within the next 7 days.

If, on the other hand, you would like more information about the study before making up your mind, please contact me on the following telephone number 0141 331 8788 or e.mail r.whyte@gcal.ac.uk. I will be very happy to answer any questions that you might have.

Yours sincerely,

Rosemary Whyte
Research Fellow
APPENDIX 15 – INFORMATION SHEET QUANTITATIVE STUDY

Study title
An evaluation of the impact of tailored smoking cessation training for members of the primary care team who have contact with older people who smoke.

Why have you been contacted?
You are being invited to take part in a study. Before you decide whether to take part it is important that you understand why the study is being carried out and what your participation would involve. Please take time to read the information carefully and discuss it with others if you wish before making up your mind.

What is the purpose of the study?
We have very recently developed smoking cessation training that is specifically tailored for health and social care professionals working in primary care who have regular weekly or monthly contact with older people who smoke. The training is, to the best of our knowledge, the first in the UK that focuses specifically on issues related to older people who smoke. As you may know, older smokers are often highly addicted to nicotine and they have generally smoked for many years. Many older smokers also started smoking before the associated dangers were known.

The aim of the training that we have developed is to provide health and social care professionals with the skills required to effectively broach the subject of smoking/smoking cessation with older people, to assess their readiness to stop smoking and to provide information on products and services that can support an older person’s attempt to stop smoking. The training is in line with what is recommended in the Standards for Smoking Cessation Training in Scotland for professionals like yourself working in the primary care setting. The training also adheres to what is in the Smoking Cessation Guidelines for Scotland. The training package has been formally approved by NHS Education for Scotland (NES) and the organisation Partnership Action on Tobacco and Health (PATH), which oversees smoking cessation training in Scotland.

As the training is the first of its kind it is important that we assess how effective it is in providing health and social care professionals with the skills required. We are, therefore inviting health and social care professionals who work in the NHS Greater Glasgow & Clyde Partnerships to take part in the training and to help us to evaluate how useful the training is.

Who is conducting the study?
The study is being undertaken by a team that includes myself (Rosemary Whyte), Susan Kerr, Hazel Watson and Debbie Tolson. We are all experienced nurses/community nurses, who are now employed as researchers in the School of Nursing, Midwifery and Community Health at Glasgow Caledonian University. We are also working with Angus McFadyen, who is a statistician in the University.

The study is funded by ASH Scotland, the Glasgow Healthy City Partnership (Glasgow City Council) and the Queen’s Nursing Institute Scotland (QNIS).
Why have you been chosen?
You have been contacted because you are a community nurse, allied health professional or social worker currently working in the NHS Greater Glasgow and Clyde Partnerships. You have been contacted along with approximately 400 other health and social care professionals working in the area. We hope that 80-100 of the 400 professionals contacted will agree to take part in the study.

If you agree to take part in the study, what will this involve?
If you agree to take part in the study, you will be invited to undertake the smoking cessation training. The training will last for one day and will be delivered by an experienced smoking cessation ‘trainer’ (Charlotte Woods) here at Glasgow Caledonian University. The training will be delivered in groups of 12-14 to the health and social care professionals who agree to participate. The training will be undertaken at two time points, at the beginning of the study (Group A) and at the end of the study (Group B). The training is free and we will provide tea/coffee and lunch.

In addition to undertaking smoking cessation training, you will also be asked to fill in a questionnaire on three occasions. Group A will complete one questionnaire, undertake the training, complete a second questionnaire just after the training and then complete a third questionnaire three months after the training. Group B, a control group, will complete the questionnaires on three occasions approximately three months apart. Once all three questionnaires have been completed Group B will undertake the training.

The questionnaires are being used to help us assess the effectiveness of the training. Studies with two groups, including a control group, are recognized as being the best type of study to assess the effectiveness of new interventions (i.e. in this case the new, specifically-tailored smoking cessation training).

Will my taking part in the study be kept confidential?
Any information that is collected about you, including your answers in the questionnaires will be kept strictly confidential. Your name will be replaced with an identification number.

What will happen to the results of the study?
The results will be published in a report that will be submitted to the funding bodies (i.e. ASH Scotland, the Glasgow Health City Partnership and the Queen’s Nursing Institute Scotland). We also plan to publish the results in nursing and social care journals and to disseminate the results at conferences as it important that we let other professionals know how useful the training has been. Please be re-assured that people who participate in the study will not be identified in any way.

If you would like a summary of the results, I will be happy to send this to you when the study is complete.

Who has reviewed the study?
The study has been reviewed by the Greater Glasgow Primary Care Division Ethics Committee (now Greater Glasgow & Clyde Partnerships) and it also has senior management approval.
What should you do if you would like to take part or if you want more information?

If you would like to take part in the study, please complete the enclosed Consent Form and return it to me in the envelope provided within the next 7 days. If, however, you would like further information about the study before making up your mind, please contact me (Rosemary Whyte) on Tel. 0141 331 8788 or r.whyte@gcal.ac.uk. I will be happy to answer any questions that you may have.

What will happen if I don’t take part?

Participation in the study is on a voluntary basis. Also, if you initially agree to participate you are free to change your mind and withdraw at any point, without providing a reason.

Finally, I am aware that some people will not wish to take part in the study because they do not have contact with older people on a regular basis. If this applies to you, it would be very helpful if you could initial the part of the 'Consent Form' that states this (see item 4 at the bottom of the first page of the Consent Form) and return it to me.

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION
APPENDIX 16 – CONSENT FORM QUANTITATIVE STUDY

Study Number: 05/S0701/154
Participant identification number:

Study title: An evaluation of the impact of tailored smoking cessation training for members of the primary care team who have contact with older people who smoke.

Name and address of Lead Researcher: Rosemary Whyte, School of Nursing, Midwifery and Community Health, Glasgow Caledonian University, Cowcaddens Road, Glasgow G4 0BA Tel: 0141 331 8788 or e mail: r.whyte@gcal.ac.uk

Please write your initials in the boxes and sign below

1. I confirm that I have read and understand the information sheet dated 25/05/06 for the above study and have had the opportunity to ask questions. □

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without providing a reason. □

3. I agree to take part in the above study. □

_________________________ ____________ ___________________
Name of participant   Date    Signature

_________________________ ____________ ___________________
Name of researcher   Date    Signature

If you wish to participate in the study please provide the following information:

Name (please print): _____________________________

Workplace address:
_____________________________________________________________________
_____________________________________________________________________

Contact telephone number at place of work: _____________________

It is important for us to know the number of health and social care professionals who may decide not to take part in the study because they do not have contact with older people. If this applies to you, please write your initials in the box below and return the form in the envelope provided:

4. I do not wish to participate in the study as I do not have contact with older people. □

Continues on next page/
If you have agreed to take part in the study the information you are asked to provide below will help us to achieve a balance of professionals when we allocate people to groups for the training. Please tick the box that identifies your professional group:

District Nurse ☐  District Nurse support ☐  Health Visitor ☐  Health Visitor support ☐  Practice Nurse ☐

**Community Older People’s Team:**

Nurse ☐  Occupational Therapist ☐  Physiotherapist ☐  Social Worker ☐
Dietician ☐  Podiatrist ☐  Other ☐  (please provide details)

Have you previously undertaken any smoking cessation training?  Yes ☐  No ☐

If you have ticked ‘yes’, please state below the type of training undertaken (e.g. One-day brief intervention training; Maudsley group training). Please print.

_________________________________________________________________
_________________________________________________________________

Please return the signed consent form in the envelope provided
<table>
<thead>
<tr>
<th>Session</th>
<th>Topic</th>
<th>Time</th>
<th>Duration</th>
<th>Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and Introductions</td>
<td>09.15</td>
<td>20 minutes</td>
<td>09.35</td>
</tr>
<tr>
<td>2</td>
<td>Training Aim &amp; Objectives</td>
<td>09.35</td>
<td>10 minutes</td>
<td>09.45</td>
</tr>
<tr>
<td>3</td>
<td>Hopes, Expectations &amp; Ground rules</td>
<td>09.45</td>
<td>20 minutes</td>
<td>10.05</td>
</tr>
<tr>
<td>4</td>
<td>Understanding Tobacco use in older adults</td>
<td>10.05</td>
<td>30 minutes</td>
<td>10.35</td>
</tr>
<tr>
<td>5</td>
<td>Smoking &amp; Health in people ≥65yrs</td>
<td>10.35</td>
<td>30 minutes</td>
<td>11.05</td>
</tr>
<tr>
<td></td>
<td><strong>Coffee Break</strong></td>
<td>11.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Brief Interventions</td>
<td>11.20</td>
<td>25 minutes</td>
<td>11.45</td>
</tr>
<tr>
<td>7</td>
<td>The role of the health professional in smoking cessation</td>
<td>11.45</td>
<td>25 minutes</td>
<td>12.10</td>
</tr>
<tr>
<td>8</td>
<td>A model of Behaviour Change</td>
<td>12.10</td>
<td>25 minutes</td>
<td>12.35</td>
</tr>
<tr>
<td></td>
<td><strong>Lunch</strong></td>
<td>12.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Raising the issue of smoking with older adults</td>
<td>13.15</td>
<td>40 minutes</td>
<td>13.55</td>
</tr>
<tr>
<td>10</td>
<td>Assessing Tobacco use and Readiness to quit</td>
<td>13.55</td>
<td>40 minutes</td>
<td>14.35</td>
</tr>
<tr>
<td>11</td>
<td>Local Smoking Cessation Services</td>
<td>14.35</td>
<td>25 minutes</td>
<td>15.00</td>
</tr>
<tr>
<td></td>
<td><strong>Coffee Break</strong></td>
<td>15.00</td>
<td></td>
<td>15.15</td>
</tr>
<tr>
<td>12</td>
<td>Exploring attitudes towards older smokers</td>
<td>15.15</td>
<td>45 minutes</td>
<td>16.00</td>
</tr>
<tr>
<td>13</td>
<td>Reflective practice</td>
<td>16.00</td>
<td>20 minutes</td>
<td>16.20</td>
</tr>
<tr>
<td>14</td>
<td>Evaluation and close</td>
<td>16.20</td>
<td>15 minutes</td>
<td>16.35</td>
</tr>
</tbody>
</table>
## APPENDIX 18 – RESPONSES KNOWLEDGE QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Questions</th>
<th>Intervention Group % of correct responses</th>
<th>Control Group % of correct responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1</td>
<td>T2</td>
</tr>
<tr>
<td><strong>1) % of people currently smoking in Scotland</strong></td>
<td>18.5</td>
<td>77.8</td>
</tr>
<tr>
<td><strong>2) % of people 65-74yrs currently smoking in Scotland</strong></td>
<td>18.5</td>
<td>59.3</td>
</tr>
<tr>
<td><strong>3) % of people 75+ yrs currently smoking in Scotland</strong></td>
<td>3.7</td>
<td>63.0</td>
</tr>
<tr>
<td><strong>4) Years lost from life expectancy by smoking</strong></td>
<td>22.2</td>
<td>48.1</td>
</tr>
<tr>
<td><strong>5a) Smoking associated with ↑ risk of bladder cancer</strong></td>
<td>63.0</td>
<td>74.1</td>
</tr>
<tr>
<td><strong>5b) Smoking associated with ↑ risk of Parkinson’s Disease</strong></td>
<td>55.6</td>
<td>92.6</td>
</tr>
<tr>
<td><strong>5c) Risk of myocardial infarction/stroke ↓ within 24hrs stopping smoking</strong></td>
<td>48.1</td>
<td>85.2</td>
</tr>
<tr>
<td><strong>5d) Stopping smoking does not stop progress of Chronic Obstructive Pulmonary Disease</strong></td>
<td>55.6</td>
<td>48.1</td>
</tr>
<tr>
<td><strong>5e) No evidence that chewing tobacco is harmful to health</strong></td>
<td>77.8</td>
<td>92.6</td>
</tr>
<tr>
<td><strong>5f) Brief intervention not shown to be cost-effective in encouraging quit attempts</strong></td>
<td>37.0</td>
<td>81.5</td>
</tr>
<tr>
<td><strong>5g) Not clear if NRT effective</strong></td>
<td>88.9</td>
<td>96.3</td>
</tr>
<tr>
<td><strong>5h) Younger people attending specialist services more likely to stop than older people</strong></td>
<td>18.5</td>
<td>59.3</td>
</tr>
<tr>
<td><strong>5i) Group support currently provided in all CHCPs in GG&amp;C</strong></td>
<td>81.5</td>
<td>92.6</td>
</tr>
<tr>
<td><strong>5j) Older people can self-refer for group support</strong></td>
<td>92.6</td>
<td>96.3</td>
</tr>
<tr>
<td><strong>5k) NRT safe for stable ischaemic heart disease</strong></td>
<td>63.0</td>
<td>92.6</td>
</tr>
<tr>
<td><strong>5l) Bupropion not recommended for cessation attempt in later life</strong></td>
<td>22.2</td>
<td>63.0</td>
</tr>
<tr>
<td><strong>5m) Less than 5% older smokers want to stop smoking</strong></td>
<td>33.3</td>
<td>81.5</td>
</tr>
<tr>
<td><strong>5n) Smoking Cessation Guidelines for Scotland - role for member of Primary Care Team is to ‘trigger’ rather than ‘support’ a quit attempt</strong></td>
<td>14.8</td>
<td>96.3</td>
</tr>
</tbody>
</table>
### APPENDIX 19 – RESPONSES ATTITUDES QUESTIONNAIRE

<table>
<thead>
<tr>
<th>+ve = positive attitude (scores 1-3)</th>
<th>~ = neither positive nor negative attitude (score 4)</th>
<th>-ve = negative attitude (scores 5-7)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reponses</strong></td>
<td><strong>Intervention Group %</strong></td>
<td><strong>Control Group %</strong></td>
</tr>
<tr>
<td></td>
<td><strong>T1</strong></td>
<td><strong>T2</strong></td>
</tr>
<tr>
<td>1) I understand what causes older people to continue smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>66.7</td>
<td>22.2</td>
</tr>
<tr>
<td>2) I have sufficient knowledge of bad effects of smoking to discuss effectively with older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>55.6</td>
<td>14.8</td>
</tr>
<tr>
<td>3) I have sufficient knowledge of benefits of stopping smoking to discuss effectively with older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>59.3</td>
<td>18.5</td>
</tr>
<tr>
<td>4) I have sufficient knowledge of barriers to stopping smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>55.6</td>
<td>25.9</td>
</tr>
<tr>
<td>5) I have sufficient knowledge of nicotine addiction/withdrawal to discuss effectively with older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33.3</td>
<td>29.6</td>
</tr>
<tr>
<td>6) Knowledge of factors encourage older people to stop smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40.7</td>
<td>18.5</td>
</tr>
<tr>
<td>7) I have right to ask older people questions about tobacco use</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>65.4</td>
<td>19.2</td>
</tr>
<tr>
<td>8) Older people believe I have right to ask about tobacco use</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>63.0</td>
<td>18.5</td>
</tr>
<tr>
<td>9) Enjoy challenge of encouraging older people to stop smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>55.6</td>
<td>14.8</td>
</tr>
<tr>
<td>10) Best I can offer is referral to someone else rather than ‘trigger’ a cessation attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>44.4</td>
<td>7.4</td>
</tr>
<tr>
<td>11) Pessimism is attitude towards successful smoking cessation for OP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>59.3</td>
<td>18.5</td>
</tr>
<tr>
<td>12) Least as effective as colleagues in encouraging smoking cessation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>77.8</td>
<td>14.8</td>
</tr>
</tbody>
</table>

65
<table>
<thead>
<tr>
<th><em>A</em>/O*=always/often</th>
<th><strong>APPENDIX 20 - RESPONSES PRACTICE QUESTIONNAIRE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>≥R/N=never/never</td>
<td>Intervention Group %</td>
</tr>
<tr>
<td></td>
<td>T1</td>
</tr>
<tr>
<td></td>
<td>A/O*</td>
</tr>
<tr>
<td>1) How often ask about older people’s smoking status</td>
<td>85.0</td>
</tr>
<tr>
<td></td>
<td>79.3</td>
</tr>
<tr>
<td>2) How often raise topic of smoking cessation</td>
<td>74.0</td>
</tr>
<tr>
<td></td>
<td>65.5</td>
</tr>
<tr>
<td>3) How often discuss readiness</td>
<td>66.6</td>
</tr>
<tr>
<td></td>
<td>58.6</td>
</tr>
<tr>
<td>4) How often encourage older people to think about stopping</td>
<td>81.5</td>
</tr>
<tr>
<td></td>
<td>58.6</td>
</tr>
<tr>
<td>5) How often discuss success rate of cessation with older people who might stop in future</td>
<td>29.6</td>
</tr>
<tr>
<td></td>
<td>26.7</td>
</tr>
<tr>
<td>6) How often discuss NRT or Zyban with older people who might stop in future</td>
<td>59.2</td>
</tr>
<tr>
<td></td>
<td>51.7</td>
</tr>
<tr>
<td>7) How often discuss specialist services with older people who might stop in future</td>
<td>48.1</td>
</tr>
<tr>
<td></td>
<td>44.8</td>
</tr>
<tr>
<td>8) How often refer older people to specialist services</td>
<td>40.7</td>
</tr>
<tr>
<td></td>
<td>17.8</td>
</tr>
<tr>
<td>9) How often record older person’s smoking status</td>
<td>81.5</td>
</tr>
<tr>
<td></td>
<td>75.8</td>
</tr>
<tr>
<td>10) How often record conversations about cessation</td>
<td>51.8</td>
</tr>
<tr>
<td></td>
<td>48.3</td>
</tr>
</tbody>
</table>

* 66
APPENDIX 21 - PARTICIPANT INFORMATION QUALITATIVE STUDY

Study title

A qualitative evaluation of the impact of tailored smoking cessation training for members of the primary care team who have contact with older people who smoke.

Why have you been contacted?

You are being invited to participate in a further part of the study of tailored smoking cessation training for primary care professionals who have regular contact with older people who smoke. Before you decide whether to take part in this part of the study it is important that you understand why it is being carried out and what your participation would involve. Please take time to read the information carefully and discuss it with others if you wish before making up your mind.

What is the purpose of the study?

As you know, we have recently delivered smoking cessation training for professionals working in primary care who have regular contact with older people who smoke. The training is, to the best of our knowledge, the first of its kind in the UK that focuses specifically on issues related to older people who smoke.

You may remember that the aim of the training is to provide health and social care professionals with the skills required to effectively broach the subject of smoking/smoking cessation with older people, to assess their readiness to stop smoking and to provide information on products and services that can support an older person’s attempt to stop smoking. We are currently assessing how useful the training has been and you have helped by filling in a questionnaire on three occasions.

The purpose of this additional part of the study is to provide a more in-depth evaluation by speaking to the professionals who undertook the training about their views of the content and delivery of the training.

Who is conducting the study?

The study is being undertaken by a team that includes myself (Rosemary Whyte), Susan Kerr, Hazel Watson and Debbie Tolson. We are all experienced nurses/community nurses, who are now employed as researchers in the School of Nursing, Midwifery and Community Health at Glasgow Caledonian University. We are also working with Angus McFadyen, who is a statistician in the University.

The study is funded by ASH Scotland, the Glasgow Healthy City Partnership (Glasgow City Council) and the Queen’s Nursing Institute Scotland (QNIS).
Why have you been asked to take part in the study?

You have been contacted because you are one of the professionals who undertook the smoking cessation training in August/September 2006.

If you agree to take part in the study, what will this involve?

If you agree to take part in the study, you will be interviewed by me (Rosemary Whyte) and, as discussed, the interview will focus on your views of the training and how useful you think the training has been. The interview will be conducted in a place of your choice (e.g. a private setting in your workplace, or at Glasgow Caledonian University) at a time that is convenient for you. The interview will take approximately 45 minutes and, if you agree, I would like to tape-record what we discuss. This is to make sure that your views are accurately represented.

Will my taking part in the study be kept confidential?

Similar to the first part of the study in which you have been involved, your name will be replaced with your personal identification number and you will not be identified by name or workplace. As part of the reporting process of a research study some parts of the participants’ conversations during the interview may be used to demonstrate their views on the training and whether or not it has been useful to their practice. However, please be re-assured that at no time will any of the participants be identified.

What will happen to the results of the study?

The results will be published in a report that will be submitted to the funding bodies (i.e. ASH Scotland, the Glasgow Health City Partnership and the Queen’s Nursing Institute Scotland). We also plan to publish the results in nursing and social care journals and to disseminate the results at conferences as it important that we let other professionals know how useful the training has been. Again, please be re-assured that people who participate in the study will not be identified in any way when the study results are reported.

If you would like a summary of the results, I will be happy to send this to you when the study is complete.

Who has reviewed the study?

The study has been reviewed by the Community & Mental Health Ethics Committee (Greater Glasgow & Clyde Partnerships). It also has senior management approval.
What should you do if you would like to take part or if you want more information?

*If you would like to take part in the study, please complete the enclosed Consent Form and return it to me in the envelope provided within the next 7 days.* If, however, you would like further information about this part of the study before making up your mind, please contact me (Rosemary Whyte) on Tel. 0141 331 8788 or r.whyte@gcal.ac.uk. I will be happy to answer any questions that you may have.

What will happen if I don’t take part?

Participation in the study is on a voluntary basis. Also, if you initially agree to participate you are free to change your mind and withdraw at any point, without providing a reason.

*THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION*
APPENDIX 22 – PARTICIPANT CONSENT FORM QUALITATIVE STUDY

Study Number: 05/S0701/154
Participant identification number:

Study title: A qualitative evaluation of the impact of tailored smoking cessation training for members of the primary care team who have contact with older people who smoke.

Name and address of Lead Researcher: Rosemary Whyte, School of Nursing, Midwifery and Community Health, Glasgow Caledonian University, Cowcaddens Road, Glasgow G4 0BA
Tel: 0141 331 8788 or e mail: r.whyte@gcal.ac.uk

Please write your initials in the boxes and sign below

1. I confirm that I have read and understand the information sheet dated 23/10/06 for the above study and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without providing a reason.

3. I agree that the interview can be tape-recorded

4. I agree to take part in the above study

_________________________ ____________ ___________________
Name of participant   Date    Signature

_________________________ ____________ ___________________
Name of researcher   Date    Signature

Name (please print): _____________________________
Workplace address: _________________________________________________
_________________________________________________________________
Contact telephone number at place of work: _____________________

Please return the signed consent form in the envelope provided.
Prior to undertaking the training

I would like to start the interview by asking you some questions about your smoking cessation practice before you undertook the training. When I talk about older people I’m talking about people aged 65 and over.

1) What percentage of your patients/clients would you say were older people (approximate in the 3-6 months before the training)? Of the older people you saw, what percentage were smokers (approximate)?

2) Before you undertook the training how often would you say you (deal with each one separately):
   - raised the issue of smoking and stopping smoking
   - provided information and advice about stopping smoking (e.g. about NRT; support services)
   - referred older people for specialist support (gp or 1-to-1)
   - pharmacy service
   (never, rarely, often, always, with reference to each one)

3) When you were working with people who smoked what factors do you think influenced your practice (in general) before you undertook the training (e.g. knowledge, attitudes, skills in raising the issue, levels of self-confidence, previous smoking cessation training, any particular barriers)?

4) Do you think that you raised the issue and provided information/advice in a way that was effective before you undertook the smoking cessation training (ask for details)?

5) Prior to the training what would you have said your role was in relation to smoking cessation and older people (ask for details, also probe to see whether clear on role)?

6) Can I just check with you about any previous smoking cessation training (if previous training undertaken ask for details, including the content and how useful the training was in relation to older people who smoke)?
Views on the training

Thinking now about the brief intervention training day that focused on smoking cessation in later life (brief recap if necessary):

1) How much of the information in the training was new to you (ask for examples of what was new, if anything)?

2) The training focused on knowledge, attitudes towards smoking cessation in later life and the skills needed to raise the issue of smoking cessation effectively:
   - Do you think the training had an impact on your knowledge of smoking cessation in later life (ask for details)? *(in what way?)*
   - Do you think your attitudes towards smoking/smoking cessation in later life altered at all (ask for details)? *(in what way?)*
   - What about skills, do you feel that you learned anything that was useful in terms of raising the issue of smoking/smoking cessation (ask for details)? *(in what way?)*

3) Tell me what you thought about the amount of information that was given during the day (ask for details)?

4) Which part/s of the training did you find the most helpful (ask for details, if anything)?

5) Was there anything in the training that wasn’t particularly useful (ask for details, if anything)?

6) Would you say that the training as a whole was pitched at an appropriate level (in relation to profession/understanding/language used)?

7) What was your overall impression of the training (ask for details)?

8) Do you think there is anything in the training that could be done differently/improved (ask for details)?
Smoking cessation practice since the training was undertaken

I would like to talk now about your smoking cessation practice since you undertook the training:

1) Has your level of contact with older patients/clients (65+ years) who smoke been similar over the last 4-5 months to what it was before you undertook the smoking cessation training (clarify if similar + explore again if daily, weekly, monthly).

2) Do you think there has been any alteration in your practice since you undertook the training in relation to (deal with each one separately):
   - raising the issue of smoking and stopping smoking
   - providing information and advice about stopping smoking (e.g. about NRT; support services)
   - referring older people for specialist support/to the pharmacy service

   (explore if a large change, a small change, no change)

3) If you feel that there has been quite a large change in your practice, what would you say has caused the change (explore knowledge, attitudes, skills, confidence, impact of the training)?

4) If you feel there has been no change or a small change, what are the reasons (explore the reasons, including any barriers; ask about colleagues’ practice (social norms), self-efficacy, support of managers)?

5) If difficulties/barriers were mentioned, do you have any views on how these barriers could be overcome (ask for details)?

6) If difficulties/barriers were mentioned, is there anything in the training that might be improved that would help to overcome these barriers (ask for details)?

7) Since you have undertaken the training what would you say your role is in relation to smoking cessation and older people (ask for details, also probe to see whether clear about role)?

That is all that I wanted to ask. Before we stop, is there anything else that you would like to add that might be useful in helping us evaluate how effective the smoking cessation training has been?