PASSEY ET AL. SMOKE-FREE HOMES: WHAT ARE THE BARRIERS, MOTIVATORS AND ENABLERS? A QUALITATIVE SYSTEMATIC REVIEW AND THEMATIC SYNTHESIS

Supplementary Table S1: Data Extract Summary of Included Studies

(Table S1 should be read in conjunction with Table S2 Critical Appraisal Summary)

Reference	Study Aims relevant to this Review	Study design	Location, setting and focus	Recruitment (and inclusion/exclusion)	Participants	Date of Data collection	Paper reports direct experience or hypothetical data around smoke-free homes	Author reported key results/headings in results section	Smoke-free policy/legislative context at time of data collection
Abdullah AS, Hua F, Xia X, et al. Second-hand smoke exposure and household smoking bans in Chinese families: a qualitative study. Health & Social Care in the Community 2012;20:356-364.	To explore why do smokers smoke around children? How much do smokers understand the hazards of smoking and SHS? What do smokers think about adopting a no smoking policy at home? How do smokers think they can quit or reduce the number of cigarettes smoked?	Qualitative	Shanghai, China. Smoking prevalence amongst Chinese men is high (cited as 60% in this paper), and low for women (6%). Focus on SHS exposure in homes with children.	Participants recruited via community health workers in one community health centre in the Xujiahui region of Shanghai. A convenience sample was selected.	4 focus groups, 10 in-depth interviews. 31 households (21 participants involved in one of four focus groups, and 10 different participants participated in in-depth interviews). Participants were parents or guardians, who were primary caregivers of children aged 5 years or under who were receiving healthcare from one community health centre in the Xujiahui region of Shanghai. Residents in this region of Shanghai are mainly middle or upper class. Focus groups (two with smokers and two with a mixed of smokers and non-smokers) were almost	July 2009	Hypothetical – none of the participants reported having total smoking bans at home.	4 key themes with subthemes were presented: 1. Knowledge of and attitude towards smoking and SHS a)Smoking and SHS hazards b)Health information sources c)Acceptance of smoking in society 2. Child health and SHS exposure a)Children's SHS exposure b)Children's SHS risk 3. Issues of smoking restrictions at home a)Smoking restrictions at home 4. Issues of SHS exposure reduction intervention a)SHS reduction counselling services b)Community health workers as interventionists	From the paper: At the time these data were collected smoke-free environments were not yet ensured in many public places including healthcare facilities, universities, government buildings, offices, restaurants, and pubs and bars.

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					entirely men (one woman, a grandmother), with an age range of 30-70. 15 were smokers and 6 were non-smokers. 12 were fathers and 9 were grandparents. 15 had less than college education, and 6 had a college education or above. 3 had a commercial job, 10 had professional or managerial jobs, 5 were retired, and 3 were a housewife or not working. All of the in-depth interviews were with women who were non-smokers and wives of smokers, and the age range was 25-35. Four of the 10 participants had a college education or above. Two had commercial jobs, 2 had professional jobs, 1 was retired and 5 were a housewife or not working. All				

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					participants in the in-depth interviews, and 6 focus group participants were non-smokers.				
Bottorff JL, Johnson JL, Carey J, et al. A family affair: Aboriginal women's efforts to limit second-hand smoke exposure at home. Canadian Journal of Public Health 2010;101:32-35.	The objective of the study was to explore factors influencing smoking in home environments, and First Nations women's efforts to minimize exposure for their children and themselves.	Qualitative (longitudinal data collection: 2-3 focus groups with the same participants over several weeks)	NW region of British Columbia, Canada. The paper states that over half of the Aboriginal population report that they smoke. Focus on SFHs (part of a larger, community based ethnographic study initiated by community members and a collaboration with university researchers, exploring ways to reduce SHS exposure).	Participants recruited via local media, presentations to community groups, and snowballing.	TOTAL sample 26 focus groups, 41 interviews. 4 individual semi-structured interviews and 25 focus groups with Group One. 1 focus group with Group Two. 37 interviews with Group Three. TOTAL participants: 70. Group One: 26 women, 17-35 years old, who were pregnant or parenting young children. 7 ex-smokers, 9 occasional smokers, 10 daily smokers. Group Two: 7 women aged 27-57 who were not primary caregivers of young children. Group Three: Key Informants – 15 community leaders in health, education, development and governance, 9 elders, 7	2006-2008	Both (participants reporting from experience and hypothetically)	1. Social dimensions of smoking in extended families 2. Structural influences on women's efforts to minimize household SHS 3. Relational factors influencing women's efforts to minimize household SHS 4. Success stories	From the paper: While there is a 20-year history of individual leaders creating smoke-free spaces in these communities, the issue of smoking in domestic space, as is the case in most communities, is unregulated. The (BC) Victorian Government's Tobacco Control Act [RSBC 1996] CHAPTER 451 states:...a person must not smoke tobacco, or hold lighted tobacco (a) in any building, structure, vehicle or any other place that is fully or substantially enclosed and (i) is a place to which the public is ordinarily invited or permitted access, either expressly or by implication, whether or not a fee is charged for entry,(ii) is a workplace, or (iii) is a prescribed place, or (b) within a prescribed distance from a doorway, window or air intake of a place described in paragraph (a). (2) Subsection (1) does not apply to the ceremonial use of tobacco (a) in relation to a traditional aboriginal cultural activity, or (b) by a prescribed group for a prescribed purpose.

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					middle aged women and 6 young people. Participants were ex-smokers, occasional smokers and current smokers who were caregivers of young children, women who were not primary caregivers, community leaders in health, education, development and governance, elders, middle aged women and young people. They were from 6 small reserve communities who identified as Gitxsan and Wet'suwet'en.				
Coxhead L, Rhodes T. Accounting for risk and responsibility associated with smoking among mothers of children with respiratory illness. Social Health Illn	Drawing on an analysis of in-depth qualitative interview accounts with mothers who smoke and whose young child was recently admitted to hospital with respiratory illness, this study describes	Qualitative	West London, England. In 2004 25% of the adult population in England smoked (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf). Focus on mothers' (of children recently admitted to hospital) constructions of risk and responsibility associated with their smoking.	All children aged three years and under admitted to a West London hospital for respiratory illnesses since September 2003 were identified. Index of Multiple Deprivation (IMD) scores used to identify those from the most deprived	9 mothers who smoked. Participants were aged 19 to 41 (mean 29); white British, white Irish and south Asian origin; for the majority care of their family was their primary responsibility; three had additional employment; five of the nine	January to April 2004	Unclear although some participants appear to have tried to make their home smoke-free	1. Stories of acceptability (a) The responsible smoker (b) Risks in perspective (c) Disputing expert views (d) The risk is acceptable but not without limits 2. Denial of agency (a) Power of addiction (b) Shift or share responsibility (c) Reflections of guilt	Data were collected prior to the UK's policies banning smoking in indoor public places and workplaces, but after the National Health Service had established the UK's (free) Stop Smoking Services to support individuals with smoking cessation. Ref: http://www.ash.org.uk/files/documents/ASH_667.pdf

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2006;28:98-121.	mothers' constructions of risk and responsibility associated with their smoking.			areas (this does not necessarily mean that individual patients were living in deprivation) and invitation letters were sent from the hospital Consultant Pediatrician to the mothers of the identified children. This was followed by a telephone call to screen for smoking status. Second wave of recruitment targeted next band on the IMD scale, plus one purposively sampled via snowballing. The sample sought to achieve a mix with respect to age, number of cigarettes smoked, caring responsibilities and marital status.	children had a chronic respiratory diagnosis; most mothers had left education at 16 years, whilst two had taken further education; mothers smoked between six and 25 cigarettes per day with two thirds smoking 15–20; three mothers were lone parents and of the six who were married or cohabiting all but one had a partner who smoked; with the exception of one, all mothers came from families where at least one parent smoked and had more close friends who smoked than did not. The sample was of varied social background.				
Escoffery C, Kegler MC, Butler S. Formative research on creating smoke-free homes in rural	The purpose of this qualitative study was to conduct formative research to inform smoke-free home	Mixed methods (interviews with open and closed questions, closed questions	3 rural counties in SW Georgia, USA. In 2004 21% of the adult population in the USA smoked (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5644a2.htm). Focus on smoking bans and smoke-free homes.	Households recruited via newspaper ads, fliers distributed at schools, word-of-mouth and fliers posted around the local community. Households	102 households. 35 (34%) total home smoking ban; 55 (54%) partial smoking ban (smoking allowed in some areas); 12 (12%). On average, homes	May 2004-Jan 2005	Mixed - mainly hypothetical but some reporting of actual experience	1. What would convince participants to adopt stricter bans 2. Difficulty in sticking with the ban 3.Asking people not to smoke in their home 4. How the	Data collected just prior to the Georgia Smoke free Air Act, (July 2005), prohibiting smoking inside most public places including state buildings, restaurants/bars serving or employing people under age 18, places of employment, auditoriums, class rooms and medical

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communities. Health Education Research 2009;24:76-86.**	interventions. The study explored: (i) the motivating factors that would convince families to adopt stricter household smoking bans and (ii) suggestions for behavioral actions to create and maintain smoke-free homes. The study also explored the impact of bans on smokers.	analysed quantitatively).		were recruited to represent a range of ban status and included households with no adult smokers, mixed smoking status and all adult smokers. Inclusion criteria were (i) a parent or caregiver of an adolescent aged 10–14, (ii) an African-American or White household, (ii) at least age 18 and (iv) English speaking.	had 2 adults (SD =0.6), 2.3 children (SD = 2.3) and 1 smoker (SD =0.9). 72 African American; 30 White. 23 households had no adult smokers in the home; 39 mixed smokers; 40 all adults smokers.			smoking restrictions affect the Smoker 5. Family discussions with smokers about quitting 6. Ideas to promote a smoke-free home	facilities. http://dhs.georgia.gov/statewide-smokefree-air-act-helps-georgians-breathe-easier

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Gould GS, Munn J, Avuri S, et al. "Nobody smokes in the house if there's a new baby in it": Aboriginal perspectives on tobacco smoking in pregnancy and in the household in regional NSW Australia. Women and Birth 2013;26:246-253.	To explore Aboriginal women and family members' views on issues around smoking in pregnancy and household smoking, in order to inform the development of an appropriate, local cessation program for pregnant Aboriginal women.	Qualitative	Regional NSW, Australia. The paper states that in Australia the prevalence of smoking in pregnant Aboriginal and Torres Strait Islander women is 49% compared with 12% for their non-Indigenous counterparts. Focus is primarily on smoking in pregnancy, and cessation, but also includes smoke-free homes	Participants were invited into the study by staff members from one local Aboriginal Maternal and Infant Health Strategy service (whose clients are Aboriginal women or female partners of Aboriginal men) and were encouraged to bring a partner or family member to the focus group. The importance of family and partners to smoking guided the sampling.	5 focus groups. 18 participants. Sixteen participants were Aboriginal and/or Torres Strait Islanders. There were 15 women and 3 men. The mean age was 30 years ± 12 years, with a range of 17-53 years. Five of the women were currently pregnant. Ten women were current smokers (3 of whom were pregnant),4 were ex-smokers (2 of whom were pregnant) and all three men smoked. One woman had never smoked. The mean Heaviness of Smoking Index was 3.08 ± 1.44 (1-5) for all smokers. Indoor smoking was reported for six of the fifteen households containing children, and in four of six households containing a pregnant woman.	February to May 2011	Direct experience	1. Social and family influences 2. Knowing and experiencing the health effects from smoking 3. Responses to health messages 4. Managing smoke-free homes and cars 5. Stress and craving 6. Giving up and cutting down 7. Community recommendations	By 2011 legislation in NSW Australia included a comprehensive smoking ban in public/work places including pubs and bars, and a ban on smoking in a vehicle containing a child (Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from www.TobaccoInAustralia.org.au)

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Herbert RJ, Gagnon AJ, Rennick JE, et al. 'Do It for the Kids': Barriers and Facilitators to Smoke-Free Homes and Vehicles. Pediatric Nursing 2011;37:23-29.	To describe factors perceived by parents as barriers to making their homes smoke-free, and to identify facilitators used by parents to manage these barriers.	Part of an RCT (which did not show a difference between intervention and control group)	This study was located across the (predominantly rural) province of Prince Edward Island, Canada. The paper cites adult smoking rates of Canadians as 19%. Focus on smoke-free homes.	Families were recruited (into the RCT) in five public health nursing offices, five family resource centres, and eight child day-care centres and kindergartens. Families eligible for inclusion included those that a) resided in a home where at least one adult smoked one or more cigarettes in the home daily, and b) had a child five years of age or younger who resided in the home at least 50% of the time.	36 participants, 1 interview each. Participants had been RCT participants in either arm. Participants were 33 mothers, 3 fathers – age range 18-42. Ethnicity not made explicit. 11 respondents (31%) had less than high school education. 16 (44%) reported annual household incomes putting them in a low SES bracket. 20 respondents (56%) were separated, divorced, widowed, or single, and 16 (44%) were married or living common-law. 21 (58%) had more than one child, and 21 (58%) had one child or more younger than two years of age. Mothers in 28 families (78%) smoked during pregnancy, and mothers in 29 families (80%) were current	Feb 2005-Feb 2007	Mixed	1. Barriers a) Intrapersonal barriers (personal factors: addiction, time and effort to make change, lack of knowledge about ETS) b) Interpersonal barriers (child factors: supervising children, preparation of children to go outside, child wanting to be with parent. Partners and relatives: smokers need/wish to smoke inside, conflict around indoor smoking, presence of smokers in the home, home/vehicle belongs to relative) c) Physical environment barriers (weather: cold, rain. Lack of access to the outdoors: upstairs apartment with no balcony) 2. Facilitators a) Intrapersonal facilitators (quit or considering quitting/reducing, change to outdoor smoking location) b) Interpersonal facilitators (talking about it to other household members, telling	The smoke-free places Act came into effect in Prince Edward Island in late 2002 (http://www.statcan.gc.ca/pub/82-003-x/2006008/article/smoking-tabac/t/4060721-eng.htm) banning smoking in all public places and workplaces (although allowing designated smoking rooms in bars and restaurants.

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					smokers; there were 18 families (50%) in which the father was a current smoker.			self/others about the change, move living location)	
Hill L, Farquharson, K., Borland, R. Blowing smoke: strategies smokers use to protect non-smokers from environmental tobacco smoke in the home. Health Promotion Journal of Australia 2003;14:196-201.	To investigate the following questions: (1) What strategies do smokers use to protect non-smokers (particularly children) from exposure to tobacco smoke in their homes? (2) How effective do they perceive their strategies to be? (3) In what circumstances in the home do smokers experience most keenly the desire to smoke? (4) What hinders smokers from making their homes smoke-free?	Qualitative	Australia (implied Victoria). In 2003 the prevalence of smoking in Victoria was 17% (http://www.cancervic.org.au/research/behavioural/research-papers/abstract_smoking_prevalence_19.html). Focus on strategies smokers in apartments use to protect non-smokers from tobacco smoke exposure in the home.	Via flyers posted in maternal and child health centres, child care centres, kindergarten, neighbourhood houses, and public housing tenants associations. Recruitment targeted people living in apartments because they were seen to face greater structural barriers to creating SFH than those living in houses, and they were more likely to be socially disadvantaged. The study recruited smokers who live with children and/or other non-smokers, who smoked indoors, and who implemented strategies to protect non-smokers from	20 interviews. 12 participants born in Australia (two of Aboriginal descent); 8 born overseas (two Greek-Australians, one Filipino, one Scottish, one Lebanese, one Maori, one American and one Uruguayan descent). 16 of 20 lived in public housing and were of low to very low socio-economic status, including single parents living on welfare benefits. 13 women, 7 men; 6 aged 21-30; 8 aged 31-40; 4 aged 41-50; 2 aged 51+. 16 participants lived with children under the age of 18. All smoked in their homes, with 13 (65%) reporting they smoked all their cigarettes in the home and the	Not reported	Difficult to differentiate but appears generally hypothetical – all participants reported smoking in the home (apartment) but most tried to employ strategies to protect non-smokers (children) from secondhand smoke. 16 of 20 reported that they desired a smoke-free home but had trouble attaining this goal which implies that they may have experience of trying to create and maintain a smoke-free home but had been unsuccessful	1. Perceived obstacles to achieving a smoke-free home; 2. Desire to smoke in warmth, comfort, and/or privacy; 3. Nicotine dependence; 4. Desire to accord with visitors' preferences for smoking indoors; 5. Lack of outdoor space; 6. Difficulties associated with supervision of children; 7. Reasons for smoking	In 2001 the Victorian Government banned smoking in all enclosed restaurants, cafes and the dining areas of hotels and licensed clubs, shopping centres, and in casinos except in designated areas (Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from www.TobaccoInAustralia.org.au).

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				tobacco smoke in the home.	remainder reporting they smoked less than half their cigarettes in the home. Three smoked <=9 cigarettes/day; 9 smoked 10-19 cigarettes/day; 6 smoked 20-29/day and 2 smoked >30/day				
Holdsworth C, Robinson JE. 'I've never ever let anyone hold the kids while they've got ciggies': moral tales of maternal smoking practices. Sociology of Health & Illness 2008;30:1086-1100.	To explore how mothers in the study recognise the risks of children's exposure to ETS and seek to regulate their own smoking practices, as well as those of other family members and adult friends to reduce perceived risks of ETS.	Qualitative	Inner-city Liverpool, England. Disadvantaged area of inner-city Liverpool, with workless rate of 44 per cent, and 18 per cent of working aged adults claiming a disability allowance. In 2008 21% of the adult population in England smoked (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf). Focus on smoking behaviour in the home.	Via Sure Start Children's Centres to take part in a project on "understanding smoking in the home". Not stated how they were recruited. Recruited families with at least one smoking parent and a child under five.	12 mothers and 5 fathers. 11 of the mothers were smokers, 1 mother's partner smoked. Children in the families ranged from 0 to 19. Range of educational and occupational backgrounds, with fluid residential and occupational histories. Ethnicity not described.	Not stated.	Mixed. Some participants reported smoke-free homes, most had partial bans.	1. Smoking rules; 2. Being a smoking mother; 3. Shared moralities; 4. Children's agency.	On the 1st July 2007, smoke-free legislation was introduced in England, banning smoking in enclosed public places (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf).

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Jochelson T, Hua M, Rissel C. Knowledge, attitudes and behaviours of caregivers regarding children's exposure to environmental tobacco smoke among Arabic and Vietnamese-speaking communities in Sydney, Australia. Ethnicity & Health 2003;8:339-351.	The aim of this study was to inform the design of a culturally appropriate health communication campaign addressing exposure of young children to second-hand smoke in homes, targeted at caregivers of children aged 0–6 years in the Arabic and Vietnamese-speaking communities in Sydney, Australia.	Qualitative	Sydney, Australia. The paper states that Arabic and Vietnamese-speaking communities in Sydney were chosen due to their high prevalence of smoking compared to the general Australian population (27% for males and 21% for females). Amongst overseas-born respondents to a national health survey, the highest rates of current daily or occasional smoking were amongst males born in Vietnam, Laos or Cambodia (44%). The lowest rates in the state for their sex were females born in Vietnam, Laos and Cambodia (1%). These figures were consistent with smoking patterns in Vietnam. The second highest smoking prevalence rates were amongst Lebanese-born males (42%). Lebanese female smoking rates (28%) were also above the state average for females. Focus on children and reduction of SHS exposure in the home – exploring knowledge, attitudes and behaviours of Arabic and Vietnamese-speaking caregivers.	Recruitment via a variety of methods including advertising in ethnically specific radio, newspapers and flyers to clients attending antenatal clinics, community health centres and early childhood centres, through informal networks of health and welfare workers, inter-agency meetings, and word of mouth. Recruitment was of Arabic and Vietnamese-speaking caregivers of children aged 0-6 years in a home setting, a smoker and/or living with a smoker. The paper does not specify if the Arabic speakers were Lebanese or from elsewhere.	9 focus groups (5 Arabic and 4 Vietmanese). 32 Arabic speakers (27 female, 5 male, 18 smokers: 14 men and 4 women, 23 non-smokers living with a smoker), 29 Vietnamese speakers (12 female, 17 male, 18 smokers: 17 male and 1 female).	October and November 2001	This study reports participants' direct experiences of reducing children's exposure to second-hand smoke (including attempts to limit smoking to outdoors only).	1. Women's powerlessness to change partners' smoking in the home 2. Birth of baby seems to change behaviours but unclear if this results in smoke-free homes, and maintenance is unclear 3. Implementing no-smoking rules in the home (difficulties, although some had found this easy) 4. Smoking as a social and cultural norm 5. Visitors and hospitality 6. Knowledge and attitudes regarding the health consequences of smoking and ETS risks and harms for children 7. Misconceptions about harms	By 2001 the Federal Government had already banned smoking in government buildings, schools, public transport and airlines and In 2000 the NSW, Australia government had banned smoking in enclosed public places although smoking was still permitted in bars, clubs, restaurants etc.

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Jones LL, Atkinson O, Longman J, et al. The Motivators and Barriers to a Smoke-Free Home Among Disadvantaged Caregivers: Identifying the Positive Levers for Change. Nicotine & Tobacco Research 2011;13:479-486.	To explore home smoking behaviours and the barriers and motivators around achieving a smoke-free home among disadvantaged caregivers and identify the positive levers for change that health care providers can utilize when supporting caregivers and their families in changing their current smoking behaviours.	Qualitative	Nottingham, England. In 2009 21% of the adult population in England smoked (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf). Focus on home smoking behaviours and motivators and barriers to achieving a smoke-free home.	Via Sure Start Children's Centres (for disadvantaged families). Not clear how potential participants were approached. Participants were disadvantaged caregivers over 16 years of age, who smoked, had at least one child under five living with them most of the time, and currently or recently smoked inside the home	22 participants, 1 interview each. 16 mothers, 1 grandmother and 5 fathers; 12 married/partnered, 1 divorced, 9 single; 3 employed, 5 housewives, 1 retired, 13 unemployed; average 2 children living in the home; 62% had ≥2 adult smokers living in the house; ethnicity not reported.	July to September 2009	Mainly hypothetical, although most had partial restrictions and some had had smoke-free homes for short periods	1. Knowledge, attitudes and beliefs: some general understanding of the harms of secondhand smoke exposure but incomplete and confused, considerable variation across participants; 2. Fluidity and complexity of home smoking rules: all had some rules around smoking restrictions in the home, but these were transient and fluid; 3. Positive behaviour change: some had implemented changes to their behaviour when they realised it was affecting their child's health, some realised how much it had affected their children's health once they had stopped smoking, others with strict rules with a new baby which gradually became relaxed; 4.Barriers to initiating a smoke-free home: complex and difficult lives (conflict between	On the 1st July 2007, smoke-free legislation was introduced in England, banning smoking in enclosed public places (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pdf).

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								caring and coping, influence on relationships, addiction, habit, boredom, privacy and comfort); 5. Motivators for initiating smoke-free homes: more strongly linked to house decor and smell than children's health, suggesting that visible evidence of the harm done by SHS to children might help promote smoke-free homes.	
Kegler MC, Escoffery C, Groff A, et al. A qualitative study of how families decide to adopt household smoking restrictions. Family & Community Health 2007;30:328-341.**	To explore the process rural White and African American families go through in adopting household smoking restrictions, with special attention paid to interpersonal influences. Specifically (1) how families decide to restrict smoking in the home; (2) who has significant influence in the decision-	Qualitative	3 rural counties in South West Georgia, USA. In 2004 21% of the adult population in the USA smoked (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5644a2.htm). Focus on home smoking behaviours	Invited to participate via newspaper ads and fliers distributed at schools, county social service agencies, and other community organizations. Recruited parents or carers of children 10-14 years old.	158 interviews (102 households – in 52 households only interviewed primary caregiver; in 50 households interviewed all adult residents). 70% African American (27% White, 3% other); 71% women; annual household income was relatively low; 33% had less than a high school education; 39% married, 19% living with someone, 42% divorced, separated,	May 2004 to January 2005	Mixed – purposively recruited participants with no home smoking ban, partial ban and complete bans	1. How families decide to restrict household smoking (a) protecting children, (b) protecting children with asthma; or bronchitis, (c) physician recommendations to protect children, (d) child aversion to smoke, (e) adult non-smoker aversion to smoke, (f) smell of cigarette smoke permeates, (g) dangers of secondhand smoke, (h) childhood environment, (i) few visitors who smoke, (j) smoking never allowed 2. Who was influential in the	Data collected just prior to the Georgia Smoke free Air Act, (July 2005), prohibiting smoking inside most public places including state buildings, restaurants/bars serving or employing people under age 18, places of employment, auditoriums, class rooms and medical facilities. http://dhs.georgia.gov/statewide-smokefree-air-act-helps-georgians-breathe-easier

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	making process; (3) the kinds of disagreements families have about household smoking restrictions; and (4) reasons some families never consider household smoking restrictions.				single, or widowed; 14% lived in households with just 1 adult, 69% had 2 adults, and 16% had more than 2 adults living in their homes; 26% lived with 1 child younger than 18 in the home, 37% had 2 children, 30% had 3 and 7% had 4 or more children. 51% smokers; 34% of the households reported a complete smoking ban, 54% reported a partial ban and 12% reported no ban.			decision to restrict household smoking? 3. Triggers and cues to action for adopting a household smoking ban; 4. Family disagreements and tensions about smoking restrictions (a) active resistance, (b) verbal resistance, (c) negotiation, (d) resignation by the non-smoker 5. Reasons families do not talk about household smoking restrictions	
Mao AM. Space and power: Young mothers' management of smoking in extended families in China. Health & Place 2013;21:102-109.	Using a gender lens, this ethnographic study explored how young mothers in extended families in mainland China managed the smoking of their husbands and other family members. This study	Qualitative (feminist ethnographical approach)	Mainland China (rural area of Central Jiangsu). This paper reports that more than 50% o fmen and less than 3% women smoke in China. Focus on home smoking behaviours.	Participants were recruited through network sampling from the families where there was at least one pre-school child aged six years or under, and at least one current smoker.	29 participants (from 22 families). 29 participants - 16 mothers of children, 5 grandmothers, 4 fathers, and 4 grandfathers. All 21 women participants were non-smokers and the 8 men participants were all smokers. Demographics for the 22 families - family	November 2008 to August 2009	Mixed – range of home smoking rules: 3 no smoking allowed in the home; 12 smoking allowed in certain rooms; 7 no restrictions and thus some had experience of trying to make their homes smoke-free	1. The autonomy and limitations of the young mothers in family affairs management 2. The young couples' domain: mothers' management of smoking in their private spaces 3. The older couples' domain: mothers' management of smoking in the private spaces of their parents-in-law 4. The common domain: mothers' management of	The Abdullah (2012) paper included in this review states that at the time these data were collected smoke-free environments were not yet ensured in many public places in China including healthcare facilities, universities, government buildings, offices, restaurants, and pubs and bars.

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	addresses two questions: (1) How do women manage family affairs in extended families? (2) How do they deal with the smoking behaviours of partner smokers and other co-resident smokers?				income (categorised A-D with A=lowest): 4 families = A (lowest income); 4 families = B; 13 families = C; 1 family = D. Family type - 1 nuclear; 21 extended (19 family living with husband's side of the family, 2 living with wife's side of the family). Smoking status within family - 3 husband smoker only; 4 father/father in law smoker only; 15 both. Household restrictions - 3 no smoking allowed in the home; 12 smoking allowed in certain rooms; 7 no restrictions.			smoking in shared spaces	

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Phillips R, Amos A, Ritchie D, et al. Smoking in the home after the smoke-free legislation in Scotland: qualitative study. British Medical Journal 2007;335:553***	To explore the accounts of smokers and non-smokers (who live with smokers) of smoking in their homes after the Scottish smoke-free legislation; the strategies they use to regulate smoking in their homes; to identify potential enablers and barriers to reducing exposure in the home; to examine the reported impact of the legislation on smoking in the home; and to consider the implications for future initiatives aimed at reducing children's exposure to secondhand smoke in the home.	Qualitative	Scotland. In 2006 25% of adults in Scotland smoked (http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendSmoking). Focus on home smoking behaviours.	Respondents were purposively recruited from Wave 10 (September-November 2005) of the health education population survey. Sampling was based on three characteristics: (1) composition of smokers in the household (smoker living alone or with another smoker, smoker living with a non-smoker, and non-smoker living with a smoker, (2) socioeconomic group and (3) sex.	50 interviews. 27 women and 23 men; 24 smokers living alone or with smokers only; 12 smokers living with any non-smokers, 14 non-smokers living with any smokers; 8 high socioeconomic status, 30 middle socioeconomic status, 12 low socioeconomic status , 9 reported a total ban on smoking in the home; 10 allowed smoking in one specific room or at an outside door; 25 allowed smoking in several rooms; 6 had no restrictions; no report on the ethnicity of the sample.	June to September 2006	Mixed - 9 reported a total ban on smoking in the home; 10 allowed smoking in one specific room or at an outside door; 25 allowed smoking in several rooms; 6 had no restrictions	1. Knowledge and understanding of risks of secondhand smoke 2. Restrictions in the home (a) patterns of restrictions; (b) how and why restrictions were developed 3. Meaning of the home and smoker identity 4. Impact of the smoke-free legislation.	The paper reports the introduction of comprehensive legislation on smoke-free public places in Scotland in March 2006, just prior to data collection. This legislation prohibited smoking in certain wholly or substantially enclosed public places (http://www.scotland.gov.uk/Publications/2005/12/21153341/33443)

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Poland B, Gastaldo D, Pancham A, et al. The interpersonal management of environmental tobacco smoke in the home - a qualitative study. Critical Public Health 2009;19:203-221.	To investigate the nature of social arrangements in the home as they pertain to the interpersonal management of second-hand smoke. Specifically, the study set out to (a) understand the nature and genesis of measures undertaken by household members to manage tobacco smoke exposure in the home; and (b) understand how social arrangements made in the home regarding tobacco smoke exposure are negotiated, modified, resisted and enforced, by whom and under what circumstances.	Qualitative (follow up study to a province-wide telephone survey (n = 1493), whose focus was also attitudes and behaviors relating to tobacco smoke exposure in the home)	Toronto, Canada. In 2000, 22% of the adult population of Ontario were daily smokers http://otru.org/wp-content/uploads/2014/02/OTRU-SMR-2013.pdf. Focus on home smoking behaviours.	Recruited from among those who agreed at the time of the telephone survey to be re-contacted. Participants were residents in the Greater Toronto Area, in households with at least one adult smoker and one resident child under 18 years of age, evidence that at least some measures had been taken to limit ETS exposure in the home, and a viable telephone number. Purposive sampling to ensure diversity of dwelling type, household composition (age – especially of children, single-parent and dual-parent households, ratio of adults to children), household income, the existence of arrangements regarding smoking in the home (for household members and for	15 interviews. The resident who responded to the telephone survey was the one who was interviewed in each household, regardless of their smoking status, since they had given consent at the time of the telephone interview to be re-contacted. 4 participants had a high degree of restriction on smoking in the home; 7 participants exhibited 'moderate' restrictions; 4 participants reported low degree of restrictions; there was a range of children in the house 1-3 (average 2); 5 households had high socioeconomic status, 7 middle socioeconomic status, and 3 low socioeconomic status.	2000	Mixed – 4 had strict rules, 7 had some fluid rules about smoking in the home and 4 had no or few restrictions	No 'traditional' themes as three comparative case summaries presented included as vignettes ((a) high degree of restrictions, (b) moderate degree of restrictions, (c) low degree of restrictions) to illustrate the substantive issues under discussion.	The paper reports that in 1994, the Ontario Tobacco Act banned smoking on school property, in health care facilities, in daycares and other public indoor venues. At the time of our study, secondhand smoke exposure was largely controlled by municipal legislation which banned smoking in worksites in some communities, including Toronto. This was the beginning of a series of bans in bars and restaurants across the province that began at that time and continued until the 2006 Smoke-Free Ontario Act covered the few remaining municipalities.

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				visitors), smoking status of household members, as well as the marital status, employment status, and educational attainment.					
Ritchie D, Amos A, Phillips R, et al. Action to achieve smoke-free homes: an exploration of experts' views. BMC Public Health 2009;9:112.***	Drawing on findings from a qualitative Scottish study, this paper identifies key issues and challenges that need to be considered when developing action to promote smoke-free homes at the national and local level.	Qualitative. Reports experts' views on the data from the Philips 2007 paper	Scotland. In 2007 26% of adults in Scotland smoked (http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendSmoking). Focus on reducing smoking in the home.	Panel members were recruited purposively from networks within Scotland. Experts included people who worked in tobacco control as part or the whole of their role, at the national and local level. This included some people who were working in community smoke-free homes initiatives.	Two expert panels. 13 participants in total (one participant appears to have taken part in both discussions). 1 Lecturer/health visitor; 1 Health promotion specialist; 1 National tobacco control alliance; 3 National Public health agency; 2 Community health partnership; 1 Voluntary organization for community smoking initiatives; 1 Smoking cessation coordinator; 1 Local health partnership; 1 Regional tobacco policy manager; 1 Public health	June 2007	Tobacco experts' views on the findings from 50 interviews which explored home smoking behaviours and so not hypothetical or experiential	1. improving knowledge about SHS among carers and professionals 2. the goal and approach of future interventions 3. the complexity of the interventions 4. issues around protecting children	The introduction of comprehensive legislation on smoke-free public places in Scotland was in March 2006. This legislation prohibited smoking in certain wholly or substantially enclosed public places (http://www.scotland.gov.uk/Publications/2005/12/21153341/33443)

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					practitioner-smoking.				
Roberts LW, M., Miller, C., Banham, D.: Parents perceptions of the pros and cons of banning smoking at home. Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals 2000, 10(3).	To investigate the factors perceived by parents to mediate the creation and maintenance of smoking bans at home.	Qualitative (following a telephone survey on health issues).	Adelaide, Australia. In 1998 the prevalence of smoking in Australia was 26% (http://www.tobaccoinaustralia.org.au/1-3-prevalence-of-smoking-adults). Focus on smoke-free homes.	Participants were asked if they would be willing to participate in the study, at the end of a representative population telephone survey about health issues. Recruited smoking parents of children under 10 years. About half agreed in principle and four focus groups were formed based on participant's availability.	4 focus groups. 33 participants. Australian and British born. 15 women, 18 men. Gender mix in the focus groups.	February 1998	Both. All participants were smoking parents. A number of participants had already implemented a SFH and therefore spoke from experience. Other participants talked hypothetically.	1. All of the parents who continued to smoke inside believed that they had made some efforts to minimize their children's exposure to smoke. 2. Those with smoke-free homes reported that there had been relatively few problems once the decision had been made 3. Reported benefits of smoking outside 4. Strategies for facilitating smoking outside 5. Causes of lapses in smoking outside.	By 1996 the Commonwealth Government had banned smoking on public transport including all air travel. Smoking was banned in airports where there was a no smoking sign. A law banning smoking in all enclosed public places, workplaces and shared areas was introduced in South Australia in 2004 well after these data were collected.
Robinson J. 'Trying my hardest': The hidden social costs of protecting children from environmental tobacco smoke. International Review of Qualitative Research	To explore the wider social lives of mothers who smoke, and the possible influence that constraints within their everyday social world may have on their smoking behaviours and their children's	Qualitative (feminist research)	Merseyside, England. In 2004 the smoking prevalence amongst adults in England was 25% (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pd). Focus on understanding the social context of women's smoking behaviour.	Women recruited through three mechanisms: 1) postal invitation using an existing research database; 2) professional recruitment agency; 3) through key community contacts including: community workers, midwives and health visitors.	54 women (average of seven women in each group; range 5-14). All participants were smokers or had quit in the previous 6 months; all had at least one child <5 living with them and 37 (of 54) had >1 child living with them at the time. The majority were white, with 2 stating they	March to April 2004	Mixed. Some participants reported smoke-free homes, most had partial bans.	1. Limited or invested agency 2. smoking and hospitality – permitting smoking within the home 3. Tolerating smoke and sustaining caring relationships 4. Avoidance of social activities 5. Smoke exposure and participation in wider social activities 6. home smoking as an expression of resistance	In 2004 the UK Government published a paper proposing smoke-free legislation to end smoking in the vast majority of workplaces and enclosed public spaces, for consideration and feedback. (http://www.ash.org.uk/media-room/press-releases/advance-media-briefing-government-consultation-on-smoking-in-workplaces)

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2008;1:173-194.Δ	exposure to tobacco smoke.			Same data set as Robinson 2007. Recruited smokers or smokers who had recently quit who had at least one child and were from socially and economically disadvantaged areas of Merseyside	were "mixed ethnic background", 2 stating they were "black" and 2 not reporting their ethnicity. Just over half were aged 25-34 years, with a quarter aged 15-24 and a quarter aged over 35 years.				
Robinson J, Kirkcaldy AJ. Disadvantaged mothers, young children and smoking in the home: Mothers' use of space within their homes. Health & Place 2007;13:894-903.Δ	To explore the smoking practices of smoking mothers with young children in their homes, and explore the complex relationship between smoking and place; to explore how the mothers' knowledge of the risks of passive smoking to their children affects their smoking behaviour within their home.	Qualitative	Disadvantaged areas of Liverpool, UK. In 2004 the smoking prevalence amongst adults in England was 25% (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pd). Focus on influences on smoking behaviour in the home	Areas selected based on deprivation indices and smoking prevalence. Individuals recruited through three mechanisms: 1) postal invitation using an existing research database from survey of smoking parents in three areas (11 women recruited from 180 contacted); 2) professional recruitment agency (35 recruited); 3) through community workers, midwives and health visitors placing posters and handing out flyers (number	7 focus groups. 54 women. 17 women had one child; 19 had two children; 18 had 3 or more. 13 were aged 15-24, 28 aged 25-34 and 13 over 35 years. Majority were white with two 'black', two 'mixed ethnic background' and two didn't identify their ethnicity. 30 women lived with a male partner, and the remainder lived alone with children (n=19) or with another female adult (n=5). 39 were full-time carers, 4 worked full time, 7 worked part time and 2	March to April 2004	Mixed. Some participants reported smoke-free homes or attempts to make their homes smoke-free but all in fact had partial bans.	1. Understanding of the risks of exposing children to ETS in the home 2. Challenging the concepts of 'non-smoking' and 'smoking homes' 3. The ad hoc nature of smoking restrictions 4. The rationale of maintaining smoking restrictions 5. Restricting smoking and the conflict with caring 6. Smoking and place	In 2004 the UK Government published a paper proposing smoke-free legislation to end smoking in the vast majority of workplaces and enclosed public spaces, for consideration and feedback. (http://www.ash.org.uk/media-room/press-releases/advance-media-briefing-government-consultation-on-smoking-in-workplaces)

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				recruited this way not specified, but presumably 8. Selected from disadvantaged areas of Merseyside with high smoking prevalence. All were smokers or had quit in the previous 6 months; all had at least one pre-school age child living with them.	were on training schemes.				
Robinson J, Kirkcaldy AJ. 'Imagine all that smoke in their lungs': parents' perceptions of young children's tolerance of tobacco smoke. Health Education Research 2009;24:11-21.Δ	To explore the factors influencing parent's behaviour in preventing the exposure of their (unborn) children to ETS and any changes to their smoking behaviour in the home during the first years of their children's lives.	Qualitative	Disadvantaged areas of Liverpool, UK. In 2004 the smoking prevalence amongst adults in England was 25% (http://www.hscic.gov.uk/catalogue/PUB11454/smok-eng-2013-rep.pd). Focus on influences on parental behaviour regarding ETS exposure during pregnancy and among young children.	Participants selected from disadvantaged areas of Mersey side with high smoking prevalence. Areas selected based on deprivation indices. Individuals recruited through three mechanisms: 1) postal invitation using an existing research database from survey of smoking parents in three areas; 2) professional recruitment agency; 3) through community workers, midwives and	10 focus groups. 54 women and 16 men (total 70). All were smokers or had quit in the previous 6 months; all had at least one child <5 living with them and 11 had children<12 months. Three women were pregnant at the time. One participant had 5 children living with them, 3 had 4 children, 21 had 3 children, 20 had 2 children, and 25 had 1 child living with them at the time. 22% were aged 15-24, 47% were 25-34, 27%	March to April 2004	Both. Some participants reported smoke-free homes, or attempts to make their homes smoke-free but all in fact had partial bans	1. Smoking during pregnancy 2. Exposure to ETS during pregnancy 3. Resuming smoking after the birth of the child 4. Exposure to ETS after the birth 5. Smoking with babies and young children	In 2004 the UK Government published a paper proposing smoke-free legislation to end smoking in the vast majority of workplaces and enclosed public spaces, for consideration and feedback. (http://www.ash.org.uk/media-room/press-releases/advance-media-briefing-government-consultation-on-smoking-in-workplaces)

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				health visitors placing posters and handing out flyers, plus snowballing from other participants.	were 35-44 and 3 were 45-54 years old. Over 90% described themselves as 'White' with two describing themselves as 'Black' and two as 'Mixed Black, Caribbean and White', with others not stating their ethnicity. Among the women, >70% were full-time carers, 4 worked full time, 5 worked part time and 2 were on training schemes. Of the 16 men, 10 worked full-time, 2 worked part-time and the rest didn't state their occupation. 51 (72%) lived with another adult who smoked and one lived with a child who smoked.				

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Robinson J, Ritchie D, Amos A, et al. Volunteered, negotiated, enforced: family politics and the regulation of home smoking. Sociology of Health & Illness 2011;33:66-80.***	To explore how positive messages about the need to protect children from tobacco smoke are transmitted and discussed by adults, and how they attempt to extend the protection of children outside their own household into that of others.	Qualitative	Scotland, UK. Focus on transmission of home smoking behaviour messages. In 2006 25% of adults in Scotland smoked (http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendSmoking). Focus on home smoking behaviours.	Two phases of recruitment. Phase 1: participants were purposively recruited from 106 people who had taken part in Wave 10 of the Health Education Population Survey (HEPS) in Scotland in 2005, with people indicating they were willing to participate in further research. Initial contact made by the British Marketing Research Bureau that had carried out HEPS, with further screening to identify participants. Recruited men and women over 18 years, based on three characteristics (1) pattern of household smoking, (2) their socioeconomic group and (3) their gender, with weighting towards lower	Phase one final sample of 50. Phase two selected 9 participants (3 smokers, 3 non-smokers, 3 living with children) from each socioeconomic group from the 14 people invited to take part. 8 were partners of Phase 1 participants and one was the mother of a phase 1 participant. All participants over 18 years. Mix of smoking status. 24 males; 35 females. 12 male and 17 females (29) who were smokers living alone or with smokers only; 7 males and 5 females who were smokers living with non-smokers (plus one female living with one of these people) (13 total); 5 males and 9 female non-smokers living with smokers (plus 3 females	Primary data collection for Phase 1 was conducted between June and September 2006 (from Phillips 2007paper). Does not state when data were collected for phase 2.	Mixed - (reported for 50 participants in Phase one) 9 reported a total ban on smoking in the home; 10 allowed smoking in one specific room or at an outside door; 25 allowed smoking in several rooms; 6 had no restrictions	1. The voluntary introduction of smoking restrictions 2. Actively negotiating home smoking restrictions 3. Enforcement of non-smoking environments with relatives	The introduction of comprehensive legislation on smoke-free public places in Scotland was introduced in March 2006, just prior to data collection. This legislation prohibited smoking in certain wholly or substantially enclosed public places (http://www.scotland.gov.uk/Publications/2005/12/21153341/33443)

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				SES. Phase 2: Second phase of interviews with other family members based on sampling strategy for Phase 1,	living with one of these people) (17 total). 10 were from SES group A&B (highest); 34 were from SES groups C1 and C2, and 15 were from SES group D.				
Wilson IS, Ritchie D, Amos A, et al. 'I'm not doing this for me': mothers' accounts of creating smoke-free homes. Health Education Research 2013;28:165-178.	To explore mothers' narratives of changing home smoking behaviours after participating in an intervention (REFRESH).	Pilot intervention study (RCT). Mixed-methods: analysis of qualitative findings illuminates quantitative changes in levels of SHS exposure. Longitudinal design, four week intervention motivational interview delivered in	Scotland, UK. In 2010 24% of the adult population in Scotland smoked http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/TrendSmoking. Focus on a smoke-free homes intervention (REFRESH).	Participants (all mothers) recruited from 23 general practitioner offices through the Scottish Primary Care Research Network.	Motivational interviews (n = 21). Semi-structured interviews (n=17). Total interview n = 38. 54 mothers in the total REFERSH sample, but only 21 included in this paper (received enhanced intervention), and 21 included in the thematic analysis with three 3 key case studies being presented. All women with ages ranging from 23-46 years (ave. 33 years). Children's ages from 1-6 years (ave. 4 years). Lived in range of accommodation types (flat/house etc.) and with a	Recruitment to the intervention took place between July 2010 and March 2011	Direct experience as participants in an intervention study	Three comparative case studies presented to illustrate the varying changes made, barriers to change and how mothers valued such changes.	Data were collected around 4 years after the introduction of comprehensive legislation on smoke-free public places in Scotland (March 2006). This legislation prohibited smoking in certain wholly or substantially enclosed public places (http://www.scotland.gov.uk/Publications/2005/12/21153341/33443)

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		week 2, followed by semi-structured interview 4-10 weeks after consent.			range of deprivation scores (averages not reported). Range of daily cigarette consumptions reported (3-20, but no average). No data reported on ethnicity but implicit that White Western sample. No report of inclusion/exclusion criteria (in abstract states smoking mothers with a child under six). Baseline home smoking restrictions varied; 5 of 21 reported smoking outside with the other 16 having mixed rules about smoking in the home from by the backdoor to everywhere but the children's room.				

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Yousey Y. Family attitudes about tobacco smoke exposure of young children at home. Mcn-the American Journal of Maternal-Child Nursing 2007;32:178-183.	To explore families' attitudes and perceptions about the effects of smoke exposure on young children and investigate the strategies they use to protect their children from smoke exposure.	Qualitative	USA (Colorado implicit). 14.5% of adults in the West Region (includes Colorado) were current smokers in 2006-7 http://appliedresearch.cancer.gov/tus-cps/results/data0607/table1.html. Focus on home smoking behaviours.	Low-income families whose children received healthcare services from school-based health centres were recruited through telephone calls and at clinic visits. Purposive sampling ensured that families with and without smoking in their homes were included and covered the possible spectrum of smoking rules and behaviours. As sample selection progressed, families who did not smoke but allowed smoking in their homes were added to explore exceptional instances. Similarly when ethnic differences emerged early in analysis, families who self-identified as Hispanic became a second exceptional	20 participants. 3 participants allowed smoking inside the home, 17 did not (although some discrepancies as the interviews progressed and 10 participants reported smoke exposure in household due to exceptions being made). 13 participants non-Hispanic White; 7 participants Hispanic; 6 participants smokers, 14 participants non-smokers; 10 participant 'households' contained no smokers ; 10 participant households contain 1 or more smokers;14 participants lived in a house; 3 in an apartment; 2 in a duplex and 1 in a mobile home. Mothers were respondents in 18 interviews; mothers and fathers jointly responded in 2 interviews. 17 interviews	Not stated.	Mixed evidence. Sample is a mixture of families who do and do not allow smoking in the home.	1. Household health promotion and protection 2. Knowledge of effects of smoke exposure 3. Attitudes and beliefs about smoke exposure 4. Reasons for smoking 5. Smoking behaviours in homes 6. Respect	Colorado - On July 1, 2006, the Colorado Clean Indoor Air Act went into effect, banning smoking in all enclosed workplaces statewide, including bars and restaurants. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6015a2.htm

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				group. Inclusion criteria: (a) ability to speak and understand English, (b) a child younger than 5 years living in the household, and (c) family eligible to receive services from school-based health centres in a metropolitan area.	occurred in a quiet clinic location and 3 in participants' homes.				

** These papers have the same data set: Escoffery 2009; Kegler 2007

*** Robinson 2011 reports on the same data set as Philips 2007 plus additional data in the Robinson paper collected in 2011. The professionals participating in the study reported by Ritchie 2009, explored data from the study reported in Philips 2007.

Δ These papers have the same data set: Robinson 2007 Disadvantaged mothers; Robinson 2008 Trying my hardest; and Robinson 2009 Imagine all that smoke (which also includes men)