Can a structured reduction approach help pregnant smokers move from ambivalence to action?

Somerset Council

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Introduction

Smokefree Families is Somerset's specialist smoking cessation service for pregnant smokers and their families, fully funded by Public Health Somerset Council. Established in 2009 and became an in-house Somerset Council service in 2025 with the introduction of honorary NHS contracts. The service delivers a comprehensive, NICE-compliant smoking cessation offer with a clear focus on achieving smokefree pregnancies and improving outcomes for women, babies and families. The service provides a wide range of evidence-based interventions, including behavioural support, nicotine replacement therapy, vaping support, financial incentives through voucher schemes, carbon monoxide self-monitoring using iCOquit devices, home visits, and support for significant others and household members to quit smoking alongside the pregnant client. As a result of sustained investment and partnership working, Somerset has achieved a substantial reduction in Smoking at the Time of Delivery (SATOD), falling from 18.9% in 2010 to 4.7% in 2026. Whilst this represents significant progress, a proportion of pregnant smokers continue to decline or disengage from traditional cessation support. The Smokefree Families service therefore continues to explore innovative, evidence-based approaches to engage those who are not ready for an immediate quit attempt, ensuring that support remains accessible, personalised and responsive to individual circumstances. The Cut Down to Stop (CDTS) pathway was developed within this context as an additional intervention designed to support pregnant smokers who are willing to change but are not yet ready to quit abruptly.

Cut Down to Stop in pregnancy

The Smokefree Families service is designed to support individuals through a structured, evidence-based approach to achieving smokefree status during pregnancy, with the clear aim of complete abstinence. The standard treatment model prioritises setting a quit date and stopping smoking in one step; however, it is recognised that for some individuals, this approach is not immediately achievable.

Within this context, the Cut Down to Stop (CDTS) approach has been introduced as an alternative, structured pathway for those who are motivated to change but are not yet ready to commit to quitting completely. Although CDTS is not recommended as a primary approach during pregnancy due to the ongoing risks associated with continued smoking, it can provide a practical and supportive option to maintain engagement with service users who may otherwise disengage from support.

The CDTS programme offers a structured period of gradual reduction in tobacco use, supported by behavioural interventions and, where appropriate, nicotine replacement therapy (NRT) or a vape, with the explicit goal of achieving complete abstinence within a defined period. Evidence-based guidance suggests that this reduction phase should

typically take place over a six-week period, allowing sufficient time to build confidence, develop coping strategies, and move towards a quit date while maintaining momentum.

This evaluation explores whether a structured CDTS programme can effectively support pregnant individuals who are not ready to stop smoking immediately. Specifically, it considers whether CDTS can:

- Maintain engagement with those unable or unwilling to set an initial quit date.
- Build trust and strengthen the therapeutic relationship with Practitioners.
- Increase motivation and confidence to quit.
- Enable individuals to set and achieve a quit date within six weeks.

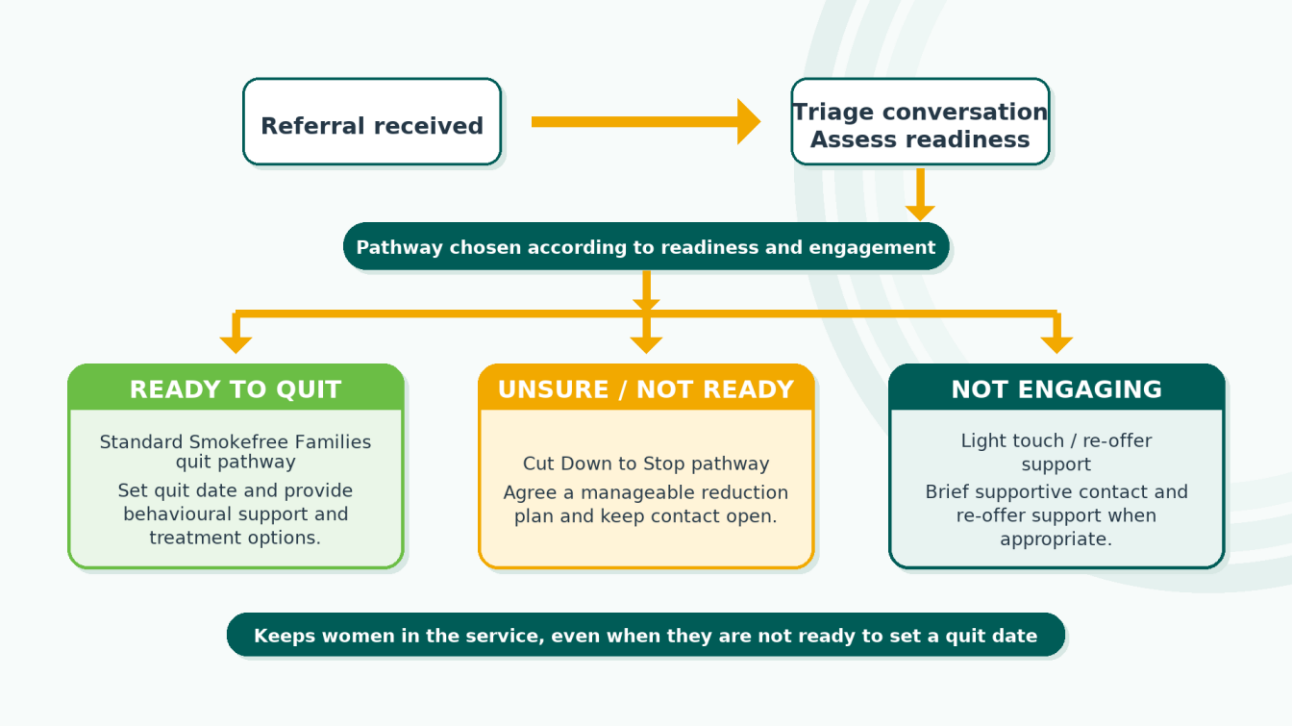
In addition, the evaluation will consider the role of NRT / vapes within this approach, both during the reduction phase to support withdrawal management and following the achievement of a quit date, where up to a further 12 weeks of treatment may be provided as part of the standard programme.

This evaluation aims to determine whether CDTS can function as an effective engagement and transition tool, supporting individuals to move from ambivalence to action, while still maintaining a clear focus on the overarching goal of complete smoking cessation in pregnancy.

CDTS Triage and Pathway Allocation

All referrals received by Smokefree Families enter the service through the same referral process and undergo an initial triage conversation to assess smoking behaviour, motivation to quit, engagement, and readiness for change. Following assessment, clients are allocated to the most appropriate pathway based on their individual circumstances and willingness to engage with smoking cessation support. Those who are ready to quit are offered the standard Smokefree Families pathway, including behavioural support, pharmacotherapy and an agreed quit date. For clients who express a desire to change but are unwilling or unable to commit to an immediate quit attempt, the Cut Down to Stop (CDTS) pathway is offered as an alternative route into support. This provides a structured and time-limited reduction programme, supported by behavioural interventions, nicotine replacement therapy and/or vaping products where appropriate, while maintaining complete abstinence as the ultimate goal. Within CDTS, practitioners work with clients to explore smoking triggers, routines and barriers to change, agree achievable reduction goals and monitor progress using carbon monoxide readings. For clients who are not engaging with support, a light-touch approach is adopted to maintain contact and periodically re-offer support. This triage model was designed to ensure that women remain connected to the service, even when they are

not ready to set a quit date, reducing the risk of disengagement and creating additional opportunities for progression towards a smokefree pregnancy.



Cut Down to Stop in Smokefree Families

Cut Down to Stop (CDTS) is a structured harm-reduction pathway within Smokefree Families for clients who are motivated to quit but unable to set an immediate quit date.

- Gradual reduction approach:
  Clients are supported to reduce their cigarette consumption in a planned way, rather than quitting abruptly, using nicotine replacement therapy (NRT) or vapes.
- Time-limited structure (6 weeks):
  The programme runs over a six-week period to maintain momentum and avoid indefinite reduction.
- Behavioural + clinical support:
  Weekly sessions focus on:
    - Understanding triggers and routines
    - Setting reduction targets

    - Monitoring progress (including CO readings)
    - Adjusting NRT use to support reduction.
- Clear end goal – full abstinence:
  Cut Down to Stop is not an alternative to quitting; it is a bridge to a quit attempt, with a quit date agreed during the programme.
- Transition to standard treatment:
  Once a quit date is set, clients move onto the standard 12-week treatment programme with continued behavioural support and medication.
- Engagement-focused model:
  It helps retain clients who may otherwise disengage, particularly those with higher complexity or lower readiness to quit.

Cohort Profile and Engagement with Cut Down to Stop

This evaluation examines service activity between 1 October 2025 and 31 March 2026, during which a total of 307 referrals were received for pregnant smokers. Of these, forty-eight pregnancies did not continue (including miscarriage, stillbirth, and termination) and two individuals moved out of the area, leaving a cohort of 257 pregnant smokers eligible for support. Within this group, forty-nine individuals engaged with the 'cut down to stop' offer, representing 19% of the eligible cohort. For those who did not wish to set a quit date, commonly reported reasons included previous unsuccessful quit attempts, perceptions of quitting as too pressurised, not feeling ready to stop, a preference to quit on their own terms, a desire to use up existing tobacco, and influence from partners who were also choosing to cut down rather than stop completely.

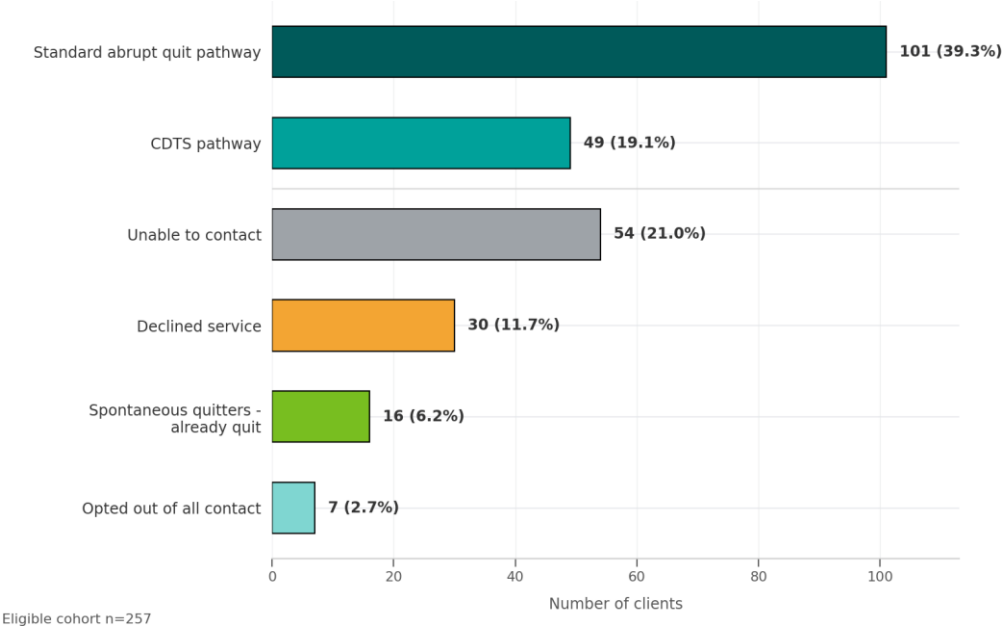
Overall, this highlights both a modest level of engagement with harm reduction approaches and the importance of addressing readiness, confidence, and external influences when supporting behaviour change during pregnancy.

Service Engagement Across the Eligible Cohort (n=257)

Of the 257 eligible pregnant smokers, 101 (39.3%) engaged with the standard Smokefree Families abrupt quit pathway and a further 49 (19.1%) engaged with the Cut Down to Stop (CDTS) pathway. Combined, this represents 150 women (58.4%) who engaged with specialist smoking cessation support during pregnancy. Of those who did not engage with a treatment pathway, 16 (6.2%) had already stopped smoking independently prior to contact, 30 (11.7%) declined support, 7 (2.7%) opted out of all contact and 54 (21.0%) could not be contacted despite repeated attempts to engage them. These findings demonstrate that while not all pregnant smokers were ready or

able to engage with behavioural support, the service successfully engaged over half of the eligible cohort through either the standard Smokefree Families pathway or the CDTS programme. Together, these pathways provided opportunities for support across a range of readiness levels, highlighting the value of offering both immediate cessation and reduction-based approaches to maximise engagement during pregnancy

58.4% of eligible pregnant smokers engaged with specialist smoking cessation support (150/257)



Cut Down to Stop: Engagement, Reduction and Quit Outcomes

The Cut Down to Stop (CDTS) dataset includes forty-nine pregnant clients who were recorded as using the CDTS pathway. The pathway was used with clients who were not ready to set an immediate abrupt quit date but were willing to engage with structured support to reduce tobacco use, with the overall aim of progressing towards complete abstinence. The data includes socioeconomic status, additional needs recording, smoking status at referral, weekly cigarette consumption / reduction, quit date setting, 4-week outcomes, 12-week outcomes and episode closure reason.

Key findings for the evaluation

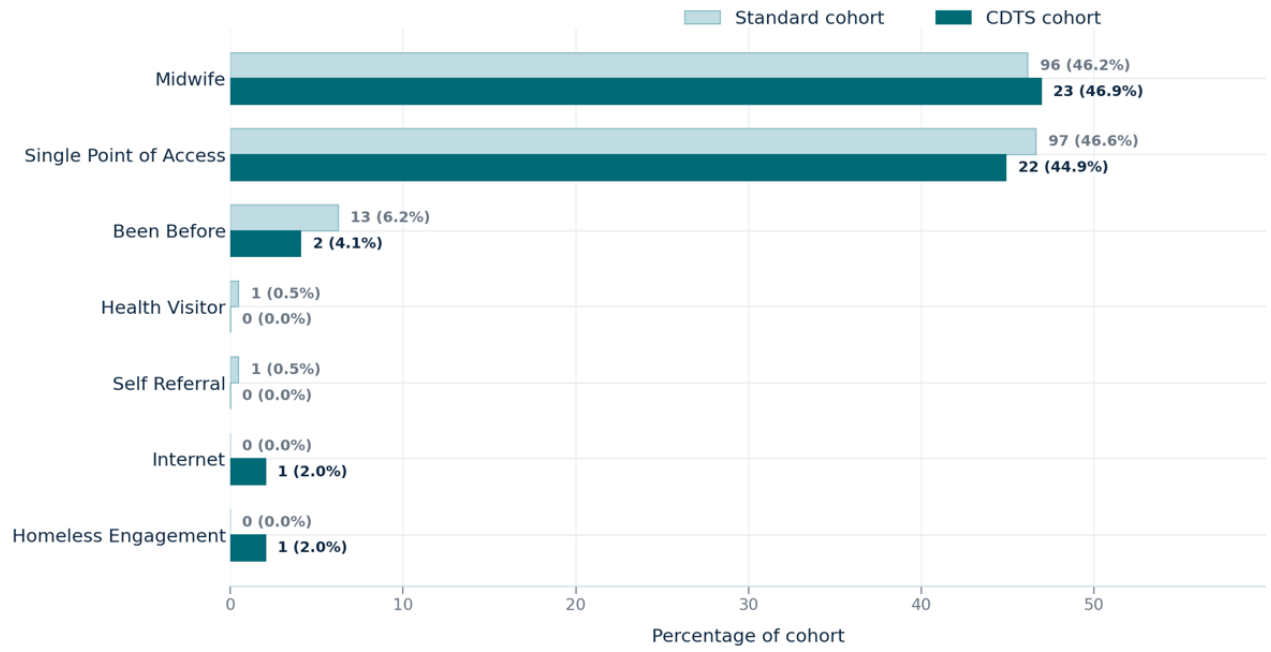
- Forty-nine pregnant clients were recorded as using CDTS.
- Thirty-five clients set a quit date, representing 71.4% of the cohort.
- Twenty-seven clients achieved a recorded CO-verified 4-week quit, representing 55.1of the whole cohort.
- Twenty-five clients achieved a recorded CO-verified 12-week quit, representing 51% of the whole cohort.
- The largest socioeconomic groups were Home Carers (Unpaid), Never Worked or Unemployed for Over 1 Year, and Routine and Manual Occupation, showing that CDTS is reaching groups where health inequalities may be more pronounced.
- Many clients presented with multiple additional needs, including poor mental health, long-term health conditions and previous substance use.
- CDTS was used across light, moderate, and heavy smokers, showing that readiness to quit is not solely determined by baseline smoking level.
- Eight clients were recorded as Not Quit or Lost to Follow-Up (LTFU) at 4 weeks, representing 16.3% of the cohort.
- Eight clients were recorded as Not Quit and two as Lost to Follow-Up (LTFU) at 12 weeks, representing 20.4% of the cohort.

Referral Route

Analysis of referral routes demonstrates that both the CDTS and standard cohorts were referred predominantly through maternity-related pathways. Within the CDTS cohort, midwives accounted for 23 referrals (46.9%) and the Midwifery Single Point of Access accounted for 22 referrals (44.9%). Similarly, within the standard cohort, 96 referrals (46.2%) came directly from midwives, and 97 referrals (46.6%) came via the Single Point of Access. Together, these routes represented over 90% of referrals in both cohorts, highlighting the crucial role of maternity services in identifying pregnant smokers and facilitating access to support.

Other referral routes accounted for only a small proportion of referrals. Within the standard cohort, 13 clients (6.2%) had previously accessed the service, whilst one referral was received from a Health Visitor (0.5%) and one was a self-referral (0.5%). Within the CDTS cohort, two clients (4.1%) had previously accessed the service, while Internet referrals and Homeless Engagement each accounted for one referral (2.0%).

The similarity in referral patterns between the two cohorts suggests that CDTS was not reaching women through a different referral mechanism. Instead, women entered the service through the same established maternity pathways as the wider Smokefree Families population. This indicates that the difference was not how women were referred into support, but the type of support pathway offered once they had entered the service.

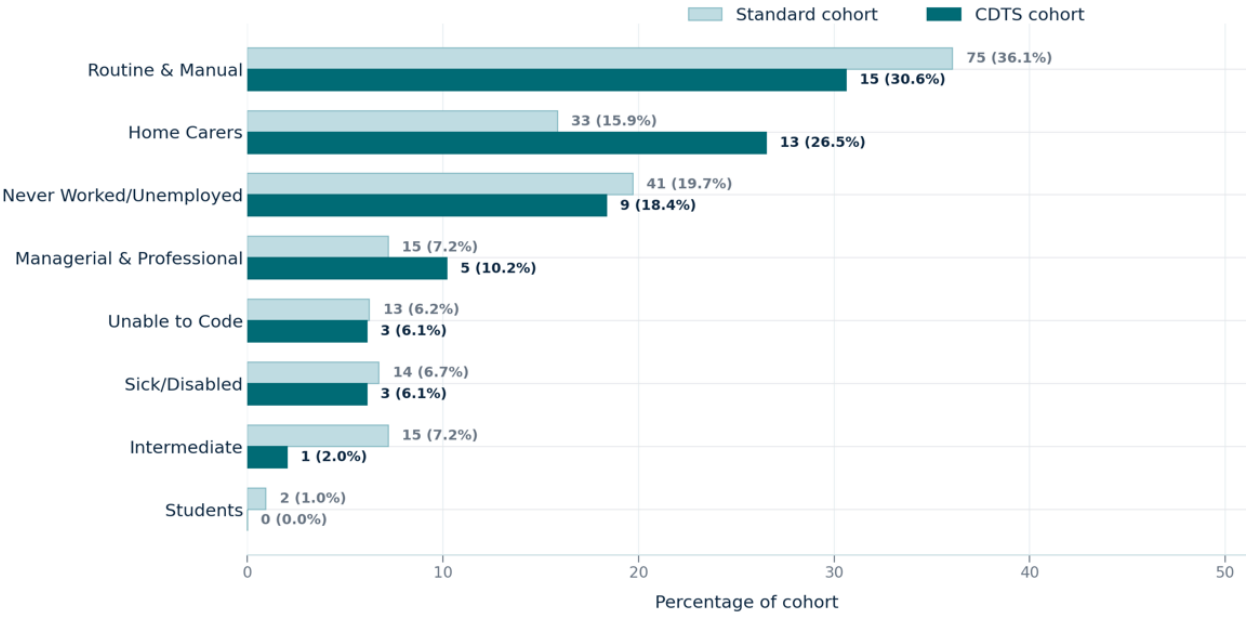


Note: standard cohort n=208; CDTS n=49. Labels show number and percentage within each cohort.

Socioeconomic Status

Comparison of the CDTS and standard cohorts demonstrates that both pathways were primarily reaching women from socioeconomic groups traditionally associated with higher smoking prevalence and increased barriers to behaviour change. In both cohorts, the largest group was those in Routine and Manual Occupations, accounting for 30.6% of the CDTS cohort (15 clients) and 36.1% of the standard cohort (75 clients). This was followed by Home Carers, who represented a higher proportion of the CDTS cohort at 26.5% (13 clients) compared with 15.9% (33 clients) in the standard cohort. Women who had Never Worked or were Unemployed accounted for 18.4% (9 clients) of the CDTS cohort and 19.7% (41 clients) of the standard cohort. Smaller proportions were observed among those in Managerial and Professional Occupations (10.2% CDTS; 7.2% standard), Sick/Disabled (6.1% CDTS; 6.7% standard), Unable to Code (6.1% CDTS; 6.2% standard), and Intermediate Occupations (2.0% CDTS; 7.2% standard). No students were recorded within the CDTS cohort, compared with 1.0% of the standard cohort.

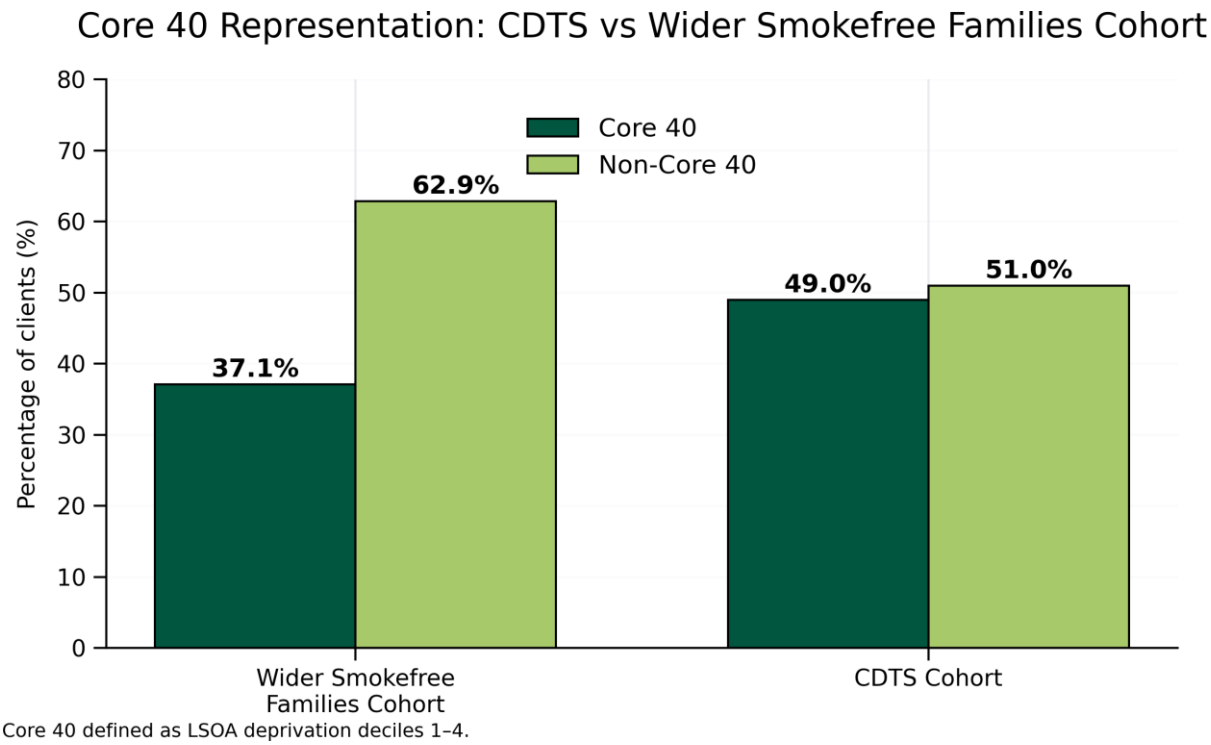
Overall, the socioeconomic profiles of the two cohorts were broadly similar, suggesting that CDTS was not attracting a substantially different population from the standard Smokefree Families pathway. Instead, CDTS appears to have provided an alternative route into support for women from the same priority groups who were not ready to engage with an immediate quit attempt. The higher proportion of Home Carers within the CDTS cohort may indicate that the flexibility of the reduction-based approach was particularly relevant for women balancing pregnancy alongside caring responsibilities. These findings suggest that CDTS can help maintain engagement with disadvantaged groups who may require additional time, confidence-building and personalised support before progressing to a quit attempt.



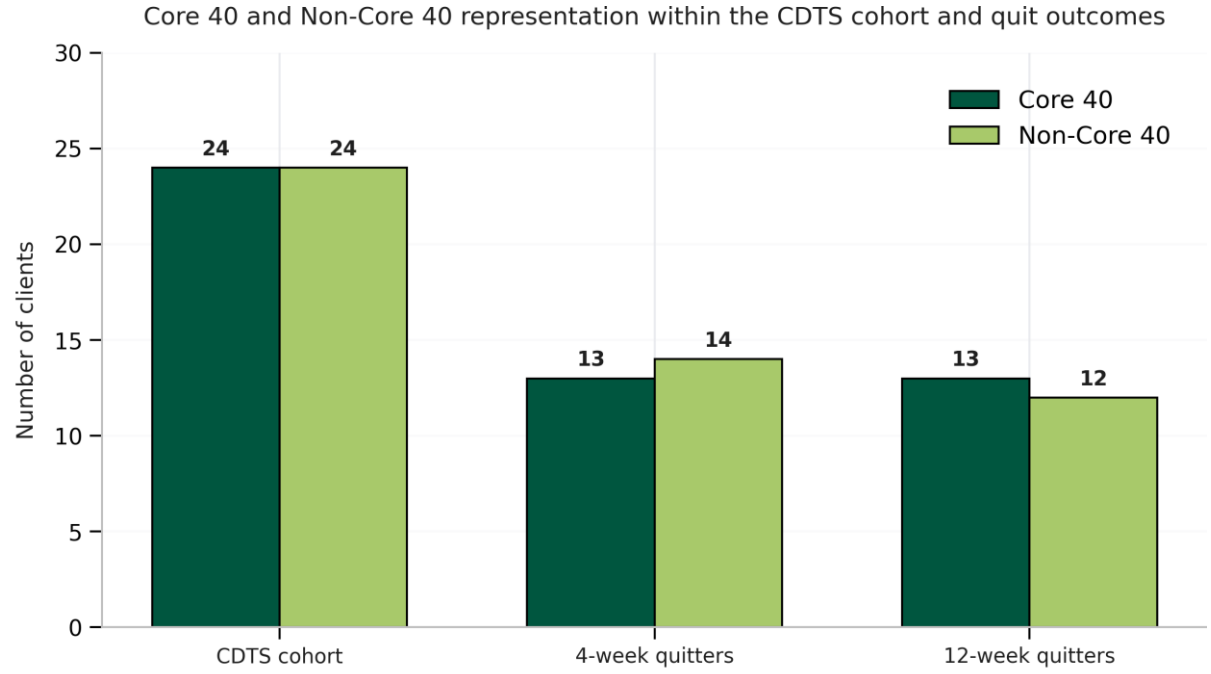
Note: standard cohort n=208; CDTS n=49. Unable to code indicates clients who did not want to share socio-economic details.

LSOA deprivation profile and Core 40 reach

Lower-layer Super Output Areas (LSOAs) are small geographical areas used nationally to describe relative deprivation at neighbourhood level. Within this evaluation, LSOA deciles have been used to identify clients living in the "Core 40" population, defined here as those living in areas ranked within deciles 1 to 4, representing the 40% most deprived areas. Among the 49 clients who accessed the Cut Down to Stop pathway, 48 had a recorded LSOA decile and one client had no recorded LSOA because they were homeless. Of those with recorded LSOA data, 24 clients were living in Core 40 areas, representing 50.0% of clients with known LSOA data and 49.0% of the full CDTS cohort. This is notably higher than the 37.1% of the wider Smokefree Families cohort living in Core 40 areas during the same period. This indicates that the pathway was reaching a substantial proportion of clients living in areas of higher deprivation. Importantly, Core 40 clients were also represented among those who achieved quit outcomes: 13 of the 27 clients who achieved a 4-week quit were from Core 40 areas, and 13 of the 25 clients who achieved a 12-week quit were from Core 40 areas.



Core 40 defined as LSOA deprivation deciles 1–4.



Core 40 defined as LSOA deprivation deciles 1 to 4. One homeless client had no recorded LSOA and is reported separately.

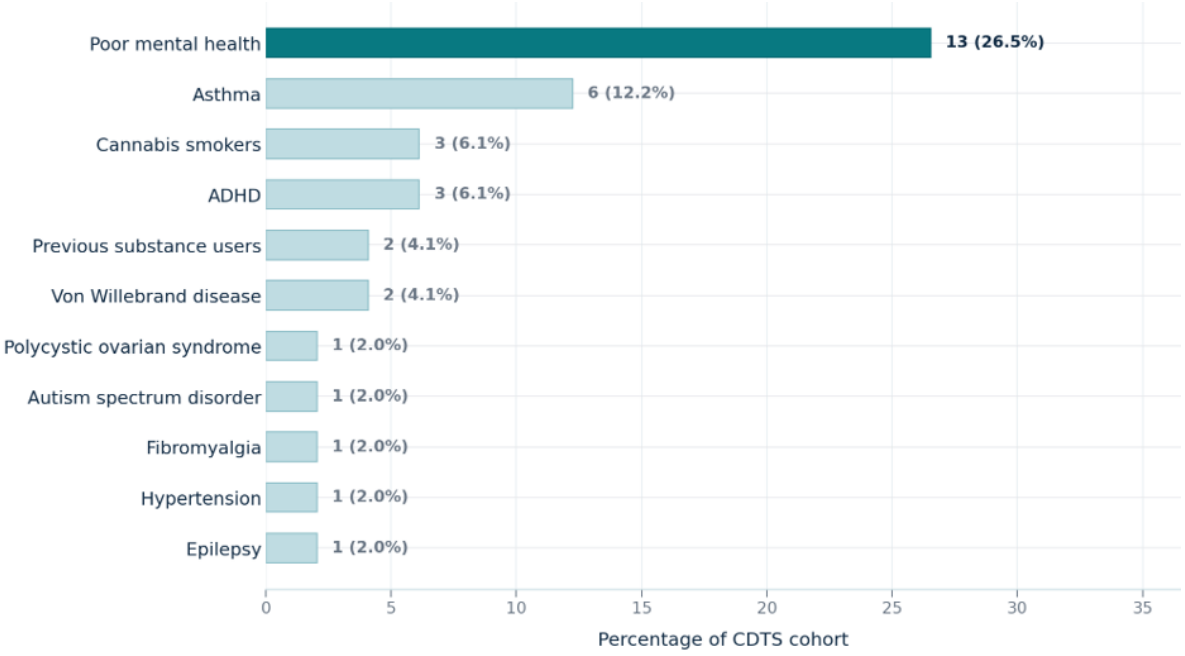
Additional Needs

Analysis of recorded additional needs demonstrates that many clients accessing the CDTS pathway were managing complex health and social circumstances alongside smoking in pregnancy. The most recorded additional need was poor mental health, affecting 13 clients (26.5%) and including conditions such as anxiety, depression, post-

traumatic stress disorder and personality disorders. Other commonly recorded needs included asthma (6 clients; 12.2%), ADHD (3 clients; 6.1%), cannabis use (3 clients; 6.1%), previous substance use (2 clients; 4.1%) and Von Willebrand disease (2 clients; 4.1%). Smaller numbers of clients reported epilepsy, hypertension, autism spectrum disorder, fibromyalgia and polycystic ovarian syndrome (1 client each; 2.0%). It is important to note that these additional needs were not mutually exclusive and some clients presented with more than one challenge.

The findings illustrate that CDTS was frequently used with women experiencing multiple and often overlapping vulnerabilities that may influence readiness, confidence and capacity to engage with a traditional abrupt quit model. The high prevalence of poor mental health, alongside long-term physical health conditions, neurodevelopmental conditions and substance use, highlights the complexity of the cohort and reinforces the importance of adopting a flexible, person-centred approach to smoking cessation support.

NICE Guideline NG209 recommends tailored smoking cessation interventions that take account of an individual's circumstances and readiness to quit. Consistent with these principles, the CDTS pathway enables practitioners to maintain engagement whilst gradually building confidence, motivation and self-efficacy towards a quit attempt. The findings suggest that CDTS may be particularly valuable for pregnant smokers facing multiple competing challenges, providing a supportive bridge towards cessation whilst maintaining a clear focus on achieving a smokefree pregnancy.

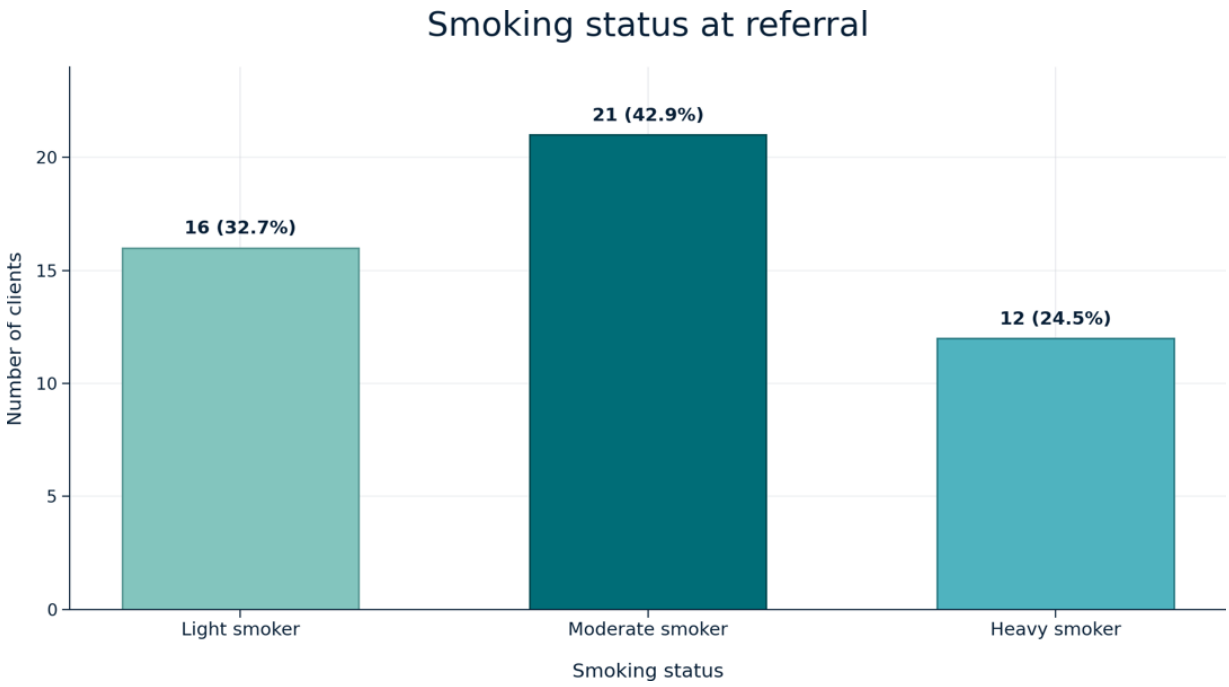


Note: additional needs may overlap; percentages are calculated from CDTS cohort n=49.

Smoking status at referral

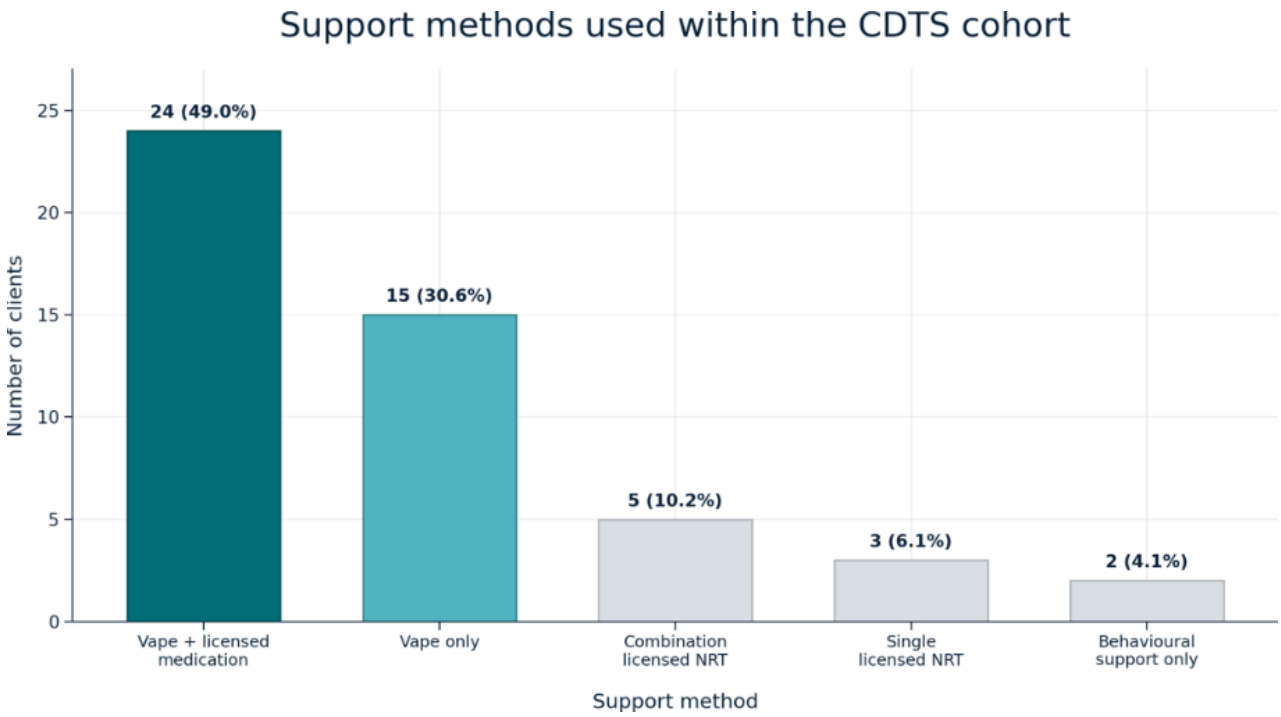
Smoking status at referral was recorded for all forty-nine clients. The largest group was Moderate Smoker, with twenty-one clients (42.9%). Light Smoker was recorded for sixteen clients (32.7%) and Heavy Smoker for twelve clients (24.5%).

This shows that CDTS was not limited to one level of smoking dependence. It was used across light, moderate, and heavy smoking groups. This is useful for the evaluation because it suggests that reluctance to set a quit date is not solely linked to the number of cigarettes smoked. Some lighter smokers still required a gradual pathway, while some heavier smokers were able to engage with reduction and, in some cases, progress to a quit date.



Methods used to support the Cut Down to Stop attempt.

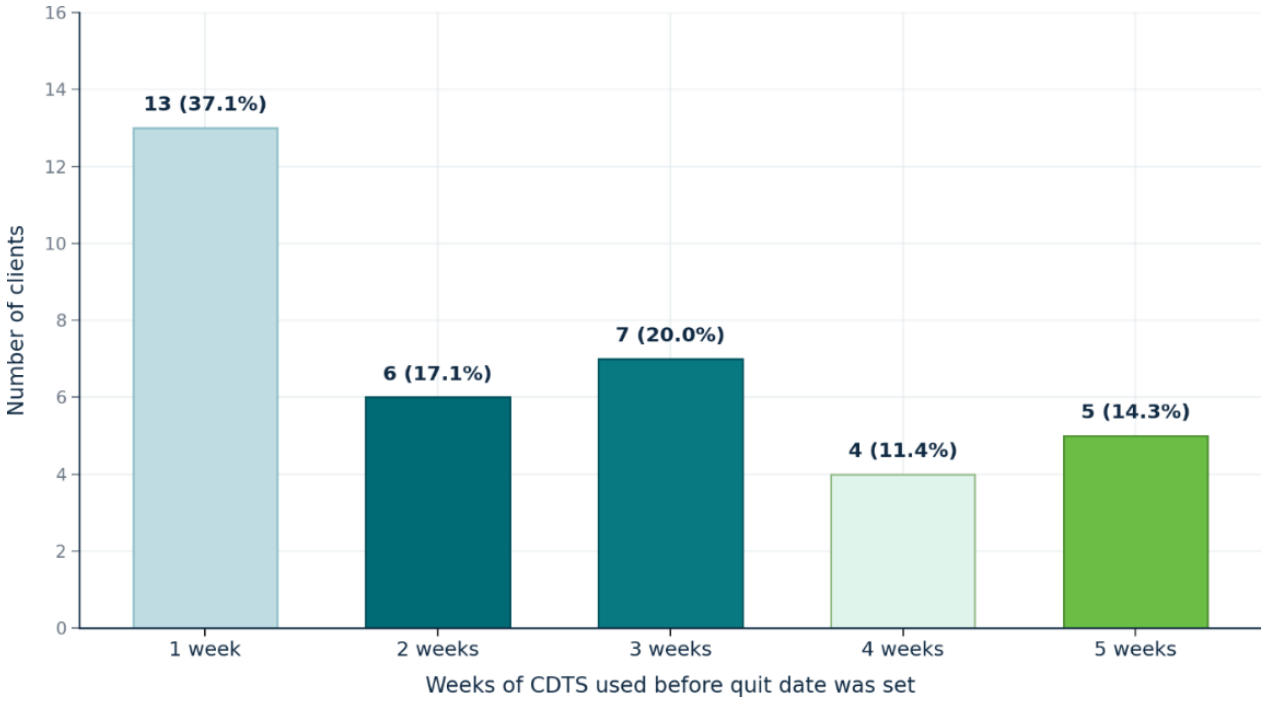
Methods used to support quit attempts within the CDTS cohort show a strong reliance on vaping, either as a standalone intervention or in combination with licensed pharmacotherapy. The most used approach was Licensed Medication combined with Unlicensed NRT (vaping), accounting for twenty-four clients (49.0%). A further fifteen clients (30.6%) used Unlicensed NRT (vaping) alone. Smaller proportions of the cohort used Combination Licensed NRT (5 clients; 10.2%) or Single Licensed NRT (3 clients; 6.1%), while two clients (4.1%) received behavioural support only. Overall, these findings indicate that vaping plays a significant role in facilitating quit attempts within this population, either independently or alongside other pharmacological options



Time Spent on CDTS Before Setting a Quit Date

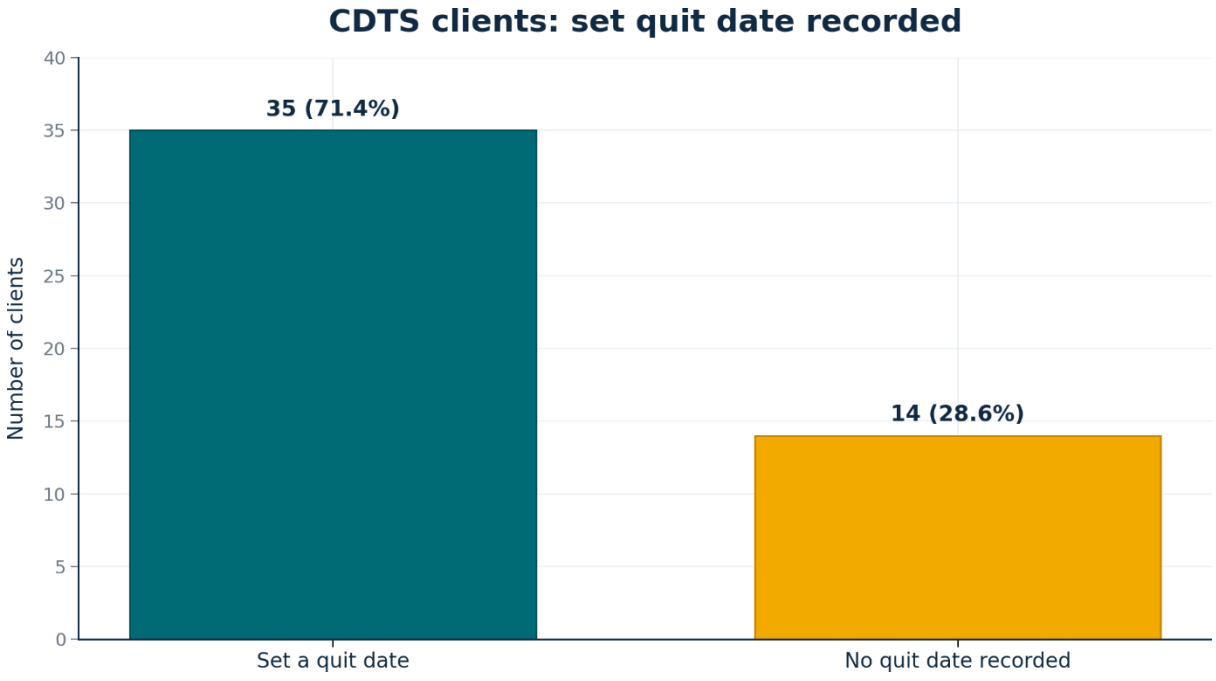
Analysis of the CDTS pathway demonstrates that women required varying amounts of time and support before feeling ready to set a quit date. Among the 35 clients who progressed to a quit date, the largest group used the CDTS pathway for approximately one week before setting a quit date, accounting for 13 clients (37.1%). A further 6 clients (17.1%) used the pathway for two weeks, whilst 7 clients (20.0%) remained on the pathway for three weeks before progressing to a quit attempt. Smaller numbers of clients required a longer period of support, with 4 clients (11.4%) using CDTS for four weeks and 5 clients (14.3%) using the pathway for five weeks prior to setting a quit date.

These findings suggest that readiness to quit varied considerably across the cohort. Whilst some women progressed rapidly to a quit attempt, others benefited from a longer period of reduction, confidence-building and behavioural support before feeling ready to stop smoking completely. This reinforces the rationale for a flexible, person-centred approach, recognising that behaviour change does not occur at the same pace for everyone. The variation observed within the cohort suggests that the CDTS pathway provided women with the opportunity to build confidence and readiness in a way that was tailored to their individual circumstances while maintaining a clear focus on achieving a smokefree pregnancy.



Quit Dates Set

Of the forty-nine clients recorded in the CDTS dataset, thirty-five clients had a quit date recorded, representing 71.4% of the cohort. A further fourteen clients, 28.6%, did not yet have a quit date recorded. This suggests that many clients on the pathway progressed to the point of setting a quit date.

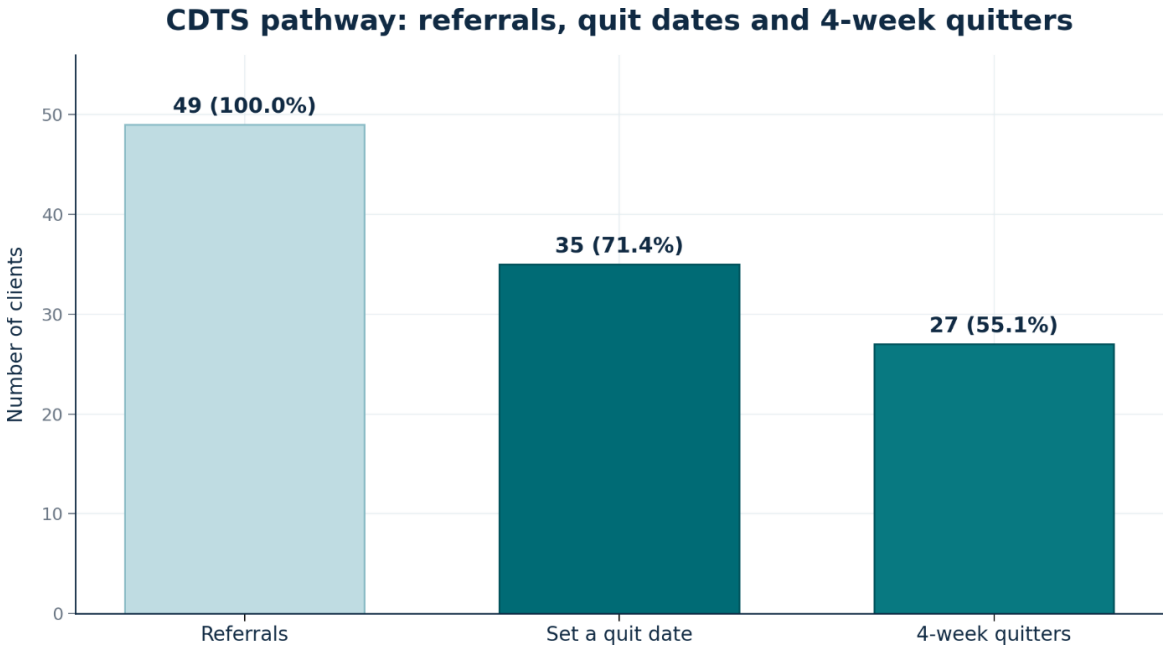


Clients Who Did Not Set a Quit Date

Whilst thirty-five clients (71.4%) progressed to setting a quit date, fourteen clients (28.6%) did not reach this stage of the pathway. Review of the recorded outcomes suggests that these clients were more likely to be recorded as not quit or lost to follow-up, indicating that they either continued smoking despite support or disengaged before a quit attempt could be established. This finding is consistent with the purpose of the CDTS pathway, which is designed to engage individuals who are not initially ready to stop smoking and may experience lower confidence, competing priorities, previous unsuccessful quit attempts, or other barriers to cessation. Although these clients did not progress to a quit date during the evaluation period, the pathway enabled practitioners to maintain contact and offer ongoing support to a group who may otherwise have declined intervention altogether. This highlights the challenges associated with supporting behaviour change among individuals with lower readiness to quit, while also demonstrating the value of CDTS as an engagement tool that provides an opportunity to build motivation and confidence over time.

4 Week Quit Outcomes

The CDTS pathway is demonstrating encouraging early outcomes, with twenty-seven of the forty-nine clients (55.1%) achieving a 4-week quit outcome. This means that more than half of all clients within the cohort successfully progressed from reducing their smoking to achieving a recorded quit at the 4-week milestone. This is particularly positive given that many clients entering the CDTS pathway presented with complex circumstances, including mental health challenges, long-term health conditions, socioeconomic disadvantage, and previous unsuccessful quit attempts. The data suggests that the gradual reduction approach offered through CDTS can support clients who may not have felt ready or able to make an immediate quit attempt through a traditional stop smoking programme.

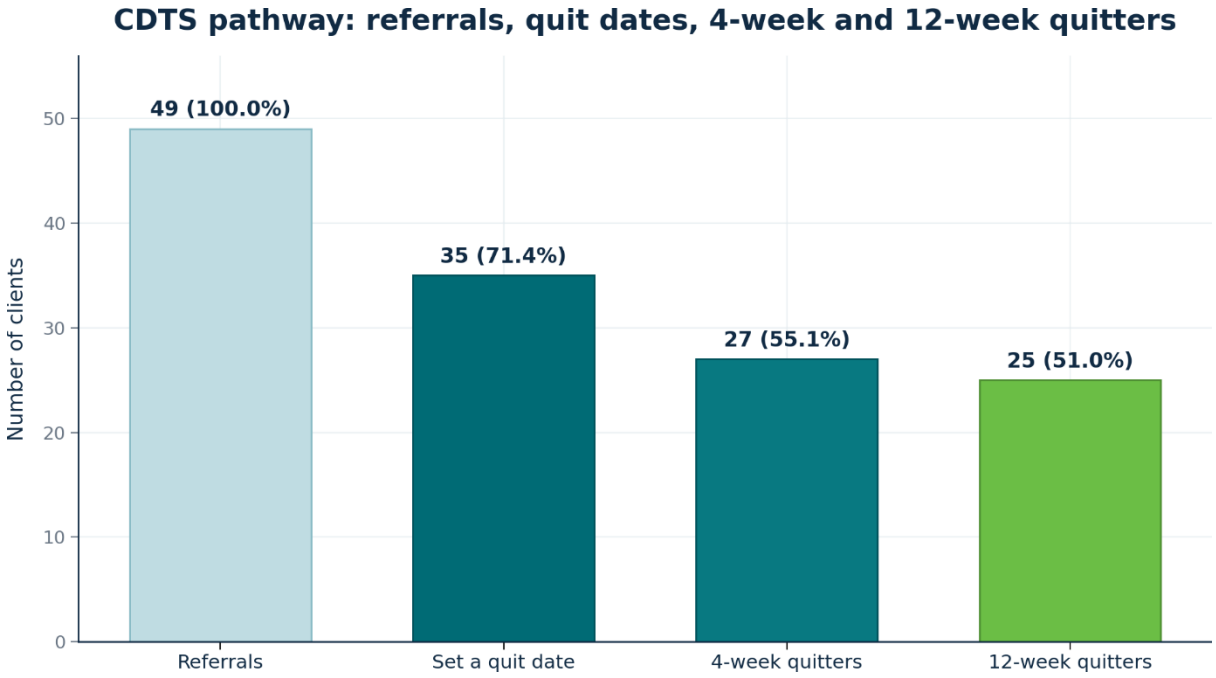


12 Week Quit Outcomes

The 12-week outcomes demonstrate encouraging evidence that many clients who achieved an early quit were able to maintain their abstinence over a longer period. Of the forty-nine clients included within the CDTS cohort, twenty-five achieved a 12-week quit outcome, representing 51.0% of all referrals. This suggests that over half of all clients entering the pathway were able to sustain their quit attempt beyond the initial 4-week milestone, suggesting that the support provided through the CDTS pathway can help clients maintain abstinence beyond the initial quit period.

The similarity between the 4-week and 12-week quit figures suggests that a substantial proportion of those who successfully quit at 4 weeks were able to maintain their quit attempt over time. This is particularly important when considering the complex needs of many clients referred into the CDTS pathway, including mental health conditions, long-term health issues, social disadvantage, and previous unsuccessful quit attempts. The findings provide early evidence that the support provided through the CDTS pathway can help clients not only to achieve a quit attempt but also to sustain abstinence beyond the immediate post-quit period.

Continued monitoring of outcomes through pregnancy and beyond will help to further understand the longer-term effectiveness of the pathway.



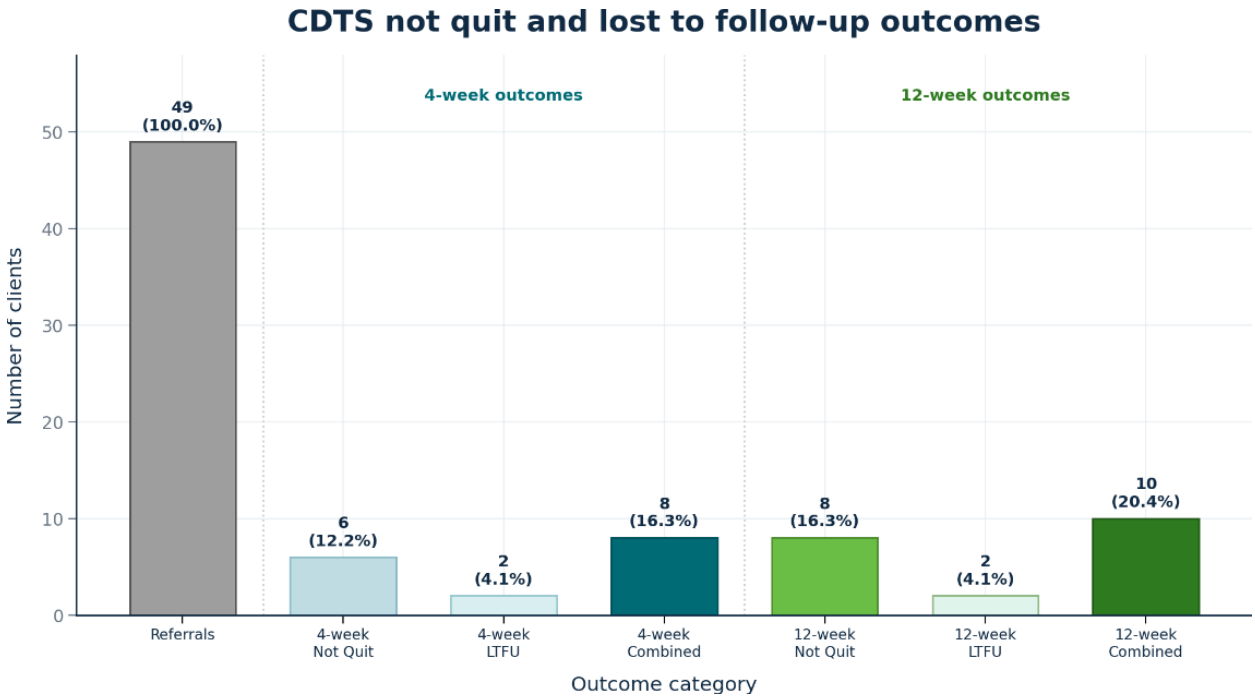
Not Quit and Lost to Follow Up Outcomes

Whilst many clients progressed to setting a quit date and many achieved successful 4- and 12-week quit outcomes, a smaller proportion either did not successfully quit or disengaged from support. At 4 weeks, six clients (12.2%) were recorded as not quit, indicating that they continued to smoke despite engaging with the pathway. In addition, two clients (4.1%) were recorded as lost to follow-up (LTFU), meaning that their outcome could not be confirmed due to disengagement from the service. Together, this represents eight clients (16.3%) who did not achieve a recorded quit outcome at 4 weeks.

At 12 weeks, 8 clients (16.3%) were recorded as not quit and two clients (4.1%) recorded as lost to follow-up. Combined, this represents ten clients (20.4%) who did not achieve a successful 12-week quit outcome.

Although these outcomes represent a minority of the overall cohort, they highlight the challenges faced by some clients in achieving and maintaining smoking abstinence during pregnancy. Many clients referred into the CDTS pathway presented with complex circumstances, including mental health conditions, socioeconomic challenges, and previous unsuccessful quit attempts, all of which can impact quit success and ongoing engagement with support. Importantly, the low proportion of clients recorded as not quit or lost to follow-up suggests that the flexible and gradual reduction approach offered through CDTS is helping many participants remain engaged long enough to progress towards cessation. Overall, the findings indicate that most clients either

achieved a quit outcome or continued to engage with support, providing further evidence that CDTS can be an effective engagement and transition tool within the Smokefree Families pathway.



Executive Summary of Findings

Of the 49 pregnant smokers who engaged with the Cut Down to Stop pathway because they were not ready to stop smoking immediately, 35 (71.4%) progressed to setting a quit date. More than half of the cohort achieved a successful 4-week quit outcome (55.1%) and 51.0% maintained abstinence to 12 weeks, demonstrating that a structured reduction approach can successfully support many individuals to transition from smoking reduction to sustained smoking cessation during pregnancy.

Key Findings and Conclusions

This evaluation suggests that the Cut Down to Stop (CDTS) pathway can be an effective engagement and transition tool for pregnant smokers who are unwilling or unable to set an immediate quit date. The findings indicate that CDTS successfully maintained engagement with a group of clients who may otherwise have declined support or disengaged from treatment, whilst keeping the focus on the goal of complete smoking cessation. Of the forty-nine clients who engaged with CDTS, 35 (71.4%) progressed to

setting a quit date, demonstrating that the majority were able to move from ambivalence about quitting to taking positive action towards stopping smoking. Importantly, CDTS was not offered as an alternative to the standard abrupt quit pathway. It was specifically targeted at pregnant smokers who were unwilling or unable to set an immediate quit date and who may otherwise have disengaged from support or continued smoking throughout pregnancy. Therefore, the quit outcomes achieved through CDTS are likely to represent additional quits in a population that may not have engaged with traditional cessation support.

The pathway also produced encouraging quit outcomes. More than half of all clients twenty-seven, achieved a 4-week quit outcome 55.1%, and 25, 51.0% achieved a 12-week quit outcome, suggesting that many clients who successfully quit were able to sustain abstinence beyond the initial quit period. The small reduction between the 4-week and 12-week quit outcomes suggests that the support provided through the CDTS pathway helped many clients maintain their quit attempt beyond the initial cessation period, despite facing significant barriers to quitting.

Importantly, the cohort included a substantial proportion of clients experiencing wider health and social challenges, including unemployment, caring responsibilities, long-term health conditions, and mental health needs. The findings therefore suggest that CDTS may have value for clients who require additional time, confidence-building, and personalised support before attempting complete cessation.

Whilst not all clients achieved a successful quit outcome, the proportion recorded as not quit or lost to follow-up remained comparatively low, with eight clients (16.3%) at 4 and 10 clients (20.4%) 12 weeks. These findings highlight the importance of ongoing work to strengthen retention and re-engagement, whilst recognising that many participants entered the pathway with complex needs and lower readiness to quit.

In conclusion, this evaluation provides encouraging evidence that CDTS can support pregnant smokers to move from ambivalence towards a successful quit attempt when an immediate abrupt quit attempt is not acceptable. Rather than acting as an alternative to stopping smoking, CDTS appears to function as an effective bridge into mainstream cessation support, increasing engagement, facilitating quit-date setting, and achieving sustained quit outcomes in a population that may otherwise have remained unsupported. For many of these clients, the alternative was not an immediate quit attempt but continued smoking without ongoing engagement with specialist support. The findings support continuation of the pathway within Smokefree Families and suggest that further evaluation with larger cohorts could strengthen the evidence base and help identify opportunities to optimise engagement, retention and long-term smokefree outcomes.

Implications for Service Delivery

The findings should be interpreted within the context of the population accessing the Cut Down to Stop pathway. Unlike a standard stop smoking programme, CDTS was specifically targeted at pregnant smokers who were unwilling or unable to set an immediate quit date and, in many cases, may not have engaged with smoking cessation support at all without the availability of a reduction-based approach. The pathway therefore provided an opportunity to engage individuals who may otherwise have remained outside of treatment, allowing practitioners to build motivation, confidence and readiness to quit over time. The fact that 71.4% of participants progressed to setting a quit date is particularly significant given that the cohort entered the programme specifically because they were not ready to stop smoking immediately. These findings suggest that CDTS may play an important role in reducing treatment barriers and expanding access to evidence-based smoking cessation support during pregnancy.

Case Study 1: Complex Physical and Mental Health Needs

This case study illustrates how the Cut Down to Stop (CDTS) approach can be effectively used for pregnant clients with complex health and social needs who may not be ready or able to quit abruptly.

Client A presented with multiple long-term physical health conditions, including endometritis, migraines, fibromyalgia, chronic fatigue, and asthma, alongside diagnosed depression and ongoing support from the Adult Mental Health Team. She also experienced chronic pain, was using multiple medications, and had additional psychosocial stressors, including a family cancer diagnosis. At the start of pregnancy, she was smoking over twenty cigarettes per day and using cannabis to manage pain, with strong emotional reliance on smoking and low confidence in her ability to quit. This combination of physical illness, poor mental health and behavioural dependence made an abrupt quit attempt unrealistic and highlighted the need for a flexible, harm-reduction approach such as CDTS.

Through CDTS, client A was supported using a trauma-informed, non-judgemental model, allowing her to gradually reduce tobacco use at a pace she could manage. This included a combination of pharmacological support (nicotine patches and vaping as the primary support), behavioural strategies (goal setting, routine changes, and removal of tobacco from the home), and self-monitoring using an iCO device to increase awareness of carbon monoxide exposure, particularly in relation to cannabis use. Despite multiple setbacks, including illness, nausea, pain flare-ups and significant emotional stress, Client A remained engaged with the service and steadily reduced her cigarette consumption over time, moving from around ten cigarettes per day to 5–6 per day prior to quitting.

Client A went on to make a self-initiated quit attempt, supported by continued use of vaping and NRT, environmental changes, and increased confidence developed through the staged reduction process. She successfully remained smokefree throughout pregnancy and into the postnatal period, with CO-verified abstinence at birth (2ppm) and sustained abstinence beyond 12 weeks. Additional positive outcomes included a reduction in cannabis use, improved coping strategies for stress and pain, and a smokefree home environment supported by her partner also remaining smokefree.

Client A's journey demonstrates that even complex clients with significant physical pain, mental health challenges, and low initial motivation can achieve a successful quit during pregnancy. A flexible, patient-centred CDTS approach, combined with consistent encouragement and tailored pharmacological support, enabled Rachel to transition from resistance ("I never want to quit") to sustained smokefree status and improved health outcomes for both mother and baby.

Case Study 2: Building Confidence Through Gradual Reduction

Case Study: Supporting Behaviour Change Through a Cut Down to Stop (CDTS) Approach

Client B, a pregnant smoker was referred to Smokefree Families smoking approximately twenty cigarettes per day and expressing a desire to quit but lacking confidence in making an immediate abrupt quit attempt. The client chose to engage with the Cut Down to Stop (CDTS) pathway and was provided with a vape alongside behavioural support focused on recognising triggers, delaying smoking, managing withdrawal symptoms, and building confidence to quit.

Over the following weeks, the client made steady progress. Within the first week cigarette consumption had reduced from twenty cigarettes per day to twelve per day through the effective use of vaping and distraction techniques. Continued support enabled further reductions to 10, then 8, 6 and eventually, 4 cigarettes per day. As withdrawal symptoms became more challenging, nicotine patches were introduced alongside vaping, demonstrating the importance of tailoring treatment to the individual's needs. The client reported that the stronger nicotine patches made a significant difference in helping manage cravings and continue reducing cigarette consumption.

An additional benefit of the CDTS model was its wider influence on the household. During one appointment, the client's partner became interested in quitting and was subsequently referred for support. This helped create a more supportive smokefree environment and strengthened the client's motivation to continue progressing towards a quit attempt.

The reduction journey was not without setbacks. At one stage, the client's vape device became unusable, resulting in a temporary increase in smoking. However, because the client remained engaged with the service, support was able to continue, barriers were addressed and the client was helped to regain momentum. Eventually cigarette consumption reduced to just three cigarettes per day, and a quit date was agreed.

Following continued support, the client successfully reduced smoking to a single cigarette per day before reaching her quit date. From this point, the client achieved complete abstinence and remained smokefree throughout the remainder of pregnancy. Carbon monoxide monitoring confirmed sustained abstinence, with CO readings reducing from 10ppm during the reduction phase to 3ppm following successful cessation. The client achieved both a CO-verified 4-week quit, and a CO-verified 12-week quit and remained smokefree through to the 36-week pregnancy milestone. During this period, the client successfully managed several potential relapse triggers including stress, family circumstances, and pregnancy-related health concerns. Relapse prevention strategies, behavioural support, and continued access to vaping played a key role in maintaining abstinence.

Although the client experienced a relapse at 8 weeks post-natal, they immediately sought further support and re-engaged with the service to work towards another quit attempt. This demonstrates the strong therapeutic relationship established through the CDTS pathway and reinforces the value of maintaining ongoing engagement even when setbacks occur.

This case demonstrates how CDTS can successfully support pregnant smokers who are not initially ready to stop smoking abruptly. By providing a structured reduction pathway, personalised behavioural support, appropriate nicotine replacement and ongoing encouragement, the client was able to reduce smoking from 20 cigarettes per day to complete abstinence, achieve both CO-verified 4-week and 12-week quit outcomes, remain smokefree throughout pregnancy and create a more supportive smokefree home environment. The case highlights how CDTS can function as an effective bridge from ambivalence and low confidence to sustained smoking cessation in pregnancy.

References

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