

Evidence relating to new tobacco control priorities that aim to protect children and young people from exposure to tobacco

Evidence review and map of tobacco control activities in the North West of England

Lisa Jones, Kerry Woolfall, Lorna Porcellato, Jim McVeigh
Centre for Public Health, Liverpool John Moores University

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Contents

Executive Summary	5
1 Introduction	8
1.1 Aims and objectives	8
2 Background.....	9
2.1 Introduction.....	9
2.2 Smoking among young people in the North West.....	10
2.2.1 Smoking prevalence.....	10
2.2.2 Intentions to quit.....	11
2.2.3 Knowledge and attitudes.....	11
2.2.4 Sources of cigarettes among young people.....	11
3 Methods	13
3.1 Mapping.....	13
3.2 Evidence review	14
3.3 Website and grey literature search	14
3.4 Synthesis.....	15
4 Mapping existing services, interventions and activities in the North West that aim to protect children and young people from exposure to tobacco	16
4.1 Sample	16
4.2 Type of service, intervention or activity.....	16
4.3 Target population	22
4.4 Location of delivery	22
4.5 Monitoring and evaluation: evidence of effectiveness	28
4.6 Funding and staffing.....	29
5 Evidence review	31
5.1 Introduction.....	31
5.2 Reducing exposure to second hand smoke.....	31
5.3 Smoking prevention	32
5.3.1 School-based programmes.....	32
5.3.2 Community-based programmes.....	34
5.3.3 Family-based programmes	34
5.3.4 Mass media interventions	35
5.3.5 Advocacy.....	35
5.4 Smoking cessation for children and young people	36
5.5 Smoking cessation for pregnant women.....	36
5.6 Reducing underage access to tobacco.....	37
6 Regional and national youth advocacy activities	38
6.1 Introduction.....	38
6.2 Regional activities	38
6.3 National activities	40

6.4	Non-tobacco control specific youth advocacy groups.....	41
7	Synthesis	42
8	Discussion and recommendations.....	46
8.1	Reducing exposure to SHS.....	46
8.2	Smoking prevention	46
8.3	Smoking cessation	48
8.4	Reducing underage access to tobacco.....	48
8.5	Conclusions.....	50
9	References.....	51
	Appendix A. Mapping questionnaire	55
	Appendix B: Mapping services, activities, programmes and interventions in the North West that aim to protect children and young people from exposure to tobacco.	58
	Appendix C: Sefton Support NHS Stop Smoking Service:Progress to target 07– 08	74
	Appendix D: Social marketing mass media campaigns aimed at young people: Sefton.....	75
	Appendix E: Social marketing mass media campaigns aimed at young people: Sefton.....	78
	Appendix F: Social marketing mass media campaigns aimed at young people: Sefton	81
	Appendix G. Supplementary information to the evidence review	83
	Appendix H. List of local youth councils in the North West.....	98

Table of figures

Figure 1. Smoking prevalence among 14-17 year olds in the North West: Trading Standards North West 2007	10
Figure 2. Cumulative percentage of smokers by age: Trading Standards North West 2007	11
Figure 3. Percentage of young people who reported purchasing cigarettes from illegitimate sources: Trading Standards North West 2007	12
Figure 4. Primary care trusts and local authorities within the North West.....	13
Figure 5. Mapping research participation by local authority	17
Figure 6. Type of tobacco related service, intervention or activity in the North West.....	20
Figure 7. Target population of tobacco related service, intervention or activity in the North West.....	22
Figure 8. Location of tobacco related service, intervention or activity in the North West	23

Table of tables

Table 1. Key action by the UK government on smoking since 1991	9
Table 2. Examples of service, intervention or activity by type in the North West	17
Table 3. Activity/service/intervention type by Local Authority and Tobacco Alliance	21
Table 4. Activity/service/intervention type by PCT and Tobacco Alliance	21
Table 5. Local targets interventions are actively monitoring work towards	28
Table 6. National targets interventions are actively monitoring work towards.....	29
Table 7. Mapping and evidence review matrix.....	42

Table 8. Reducing exposure to second hand smoke.....	83
Table 9. School-based programmes.....	85
Table 10. Community-based programmes.....	88
Table 11. Family-based programmes	90
Table 12. Mass media.....	91
Table 13. Smoking cessation programmes for young people.....	92
Table 14. Smoking cessation programmes for pregnant women	94
Table 15. Reducing underage access to tobacco.....	95
Table 16. Quality assessment for systematic reviews included in the evidence review.....	97

Executive Summary

Objectives

The mapping and evidence review was undertaken on behalf of Smokefree North West (SFNW) and sought to (i) map existing services, interventions and activities in the North West that aim to protect children and young people from exposure to tobacco; (ii) identify effective interventions that protect children and young people from exposure to tobacco; (iii) compile case studies of national and regional youth advocacy activities; and (iv) develop recommendations for future smoking prevention, tobacco control and health promotion activities and services in the North West.

Methods

The mapping sought to identify services or interventions targeted at both adults and children and young people, including smoking prevention, cessation and tobacco control as all have a direct or indirect impact upon young people's exposure to tobacco. Programmes were identified by contacting organisations and/or networks who deliver services for young people across the 24 Primary Care Trusts (PCTs) and 43 local authorities within the North West. The aim of the literature review was to bring together evidence from good quality systematic reviews and meta-analyses that have examined the effectiveness of interventions designed to protect children and young people from exposure to tobacco, including interventions designed to reduce second hand smoke exposure. The evidence review and mapping were supplemented by a search of the grey literature and the Internet to identify details of relevant national and regional youth advocacy activities that have been conducted since 2007.

A matrix was developed to synthesise the findings of the mapping and evidence review. The results of the mapping exercise were presented alongside the key themes arising from the evidence review to give an indication of the range and scope of tobacco control activities in the North West. The matrix was used as the basis for the development of recommendations to support the development of future smoking prevention, tobacco control and health promotion activities and services in the North West.

Recommendations

The findings of the mapping showed that a range of approaches that both directly and indirectly aim to protect children and young people from exposure to tobacco are in place across the North West. These include services targeting adults, children, young people, pregnant women and programmes that aim to reduce underage sales and enforce smoke free legislation.

Reducing exposure to second hand smoke (SHS)

Most SHS exposure among children occurs within the home or car, and smoke free home schemes and/or training on SHS are being delivered or developed in a number of areas across the North West. The evidence review identified that a range of interventions have been used to try to reduce exposure, at both an individual and population level. Although there is no clear evidence for the most effective

approaches which target individual behaviours, there is limited support for interventions based on intensive counselling for families and carers within a clinical setting, and home-based interventions.

Recommendation 1: Smoke free NW should ensure that smoke free home schemes and training on SHS are being implemented region-wide. Schemes should be developed at a local level and evaluated.

Smoking prevention

The mapping identified that schools were a popular setting for the delivery of smoking prevention activities, but it is unclear whether a consistent approach is being taken across the region. The evidence review identified that there is some evidence that school programmes incorporating social influences models (e.g. those based on Life Skills) can affect smoking behaviour in the short term, however there is limited evidence that these approaches are effective in the long term. New approaches to smoking prevention within the school setting, such as ASSIST (a peer-led approach targeting social networks within in schools), have shown promise.

Recommendation 2: Smokefree North West should ensure that school-based programmes are based on the best available evidence (i.e. social influence approaches). In addition, Smokefree North West may wish to consider conducting a region-wide evaluation of new approaches such as the peer-led intervention evaluated in the ASSIST trial.

Comprehensive community-wide interventions that incorporate a range of tobacco control activities have been shown to be more effective than school-based intervention alone. The results of the mapping indicated that across the NW, services are being delivering across a variety of locations in addition to schools. However, currently a strong evidence base is lacking for the effectiveness of family-based interventions.

Mass media campaigns have been shown to be effective in preventing the uptake of smoking in young people, particularly when combined with other intervention approaches. Campaigns of longer duration and higher intensity appear to more effective, and developmental work should be carried out with representative samples of the target audience prior to delivery. The mapping identified that Sefton was the only area in the North West that was currently delivering a coordinated mass media campaign targeting young people.

Recommendation 3: Smokefree North West should implement NICE guidance (see Box 2) and develop regional and/or local mass media campaigns to prevent the uptake of smoking among young people. Regional and local campaigns should build on, and be integrated with, a national communications

Smoking cessation

The mapping identified that some cessation services in the North West are specifically targeting young people, such as the Stop Smoking Clinics which have been implemented in high schools across Blackpool. Research regarding smoking cessation interventions for adolescents is at an early stage, and there is currently insufficient evidence to suggest which particular approaches are most

effective. However, complex programmes, including those based on motivational enhancement, cognitive-behavioural therapy and 'stage of change' theory have demonstrated success. Studies that have examined the effectiveness of NRT and pharmacological approaches to cessation with young people are inconclusive.

Recommendation 4: Given that the evidence base regarding smoking cessation interventions for young people is at an early stage, Smokefree North West should prioritise the evaluation of existing regional and local services.

Reducing underage access to tobacco

The mapping identified that a range of enforcement activities are conducted across the North West. The evidence review highlighted that interventions with multiple components are most effective for reducing youth access to tobacco, particularly when combined with ongoing enforcement. Law enforcement or multi-component education programs are more effective than informing retailers of minimum age restrictions. The success of access restrictions may be limited by youth's ability to access tobacco products from social sources.

Recommendation 5: Smokefree North West should implement NICE guidance (see Box 3) and take action to make it as difficult as possible for young people under 18 to get cigarettes and other tobacco products.

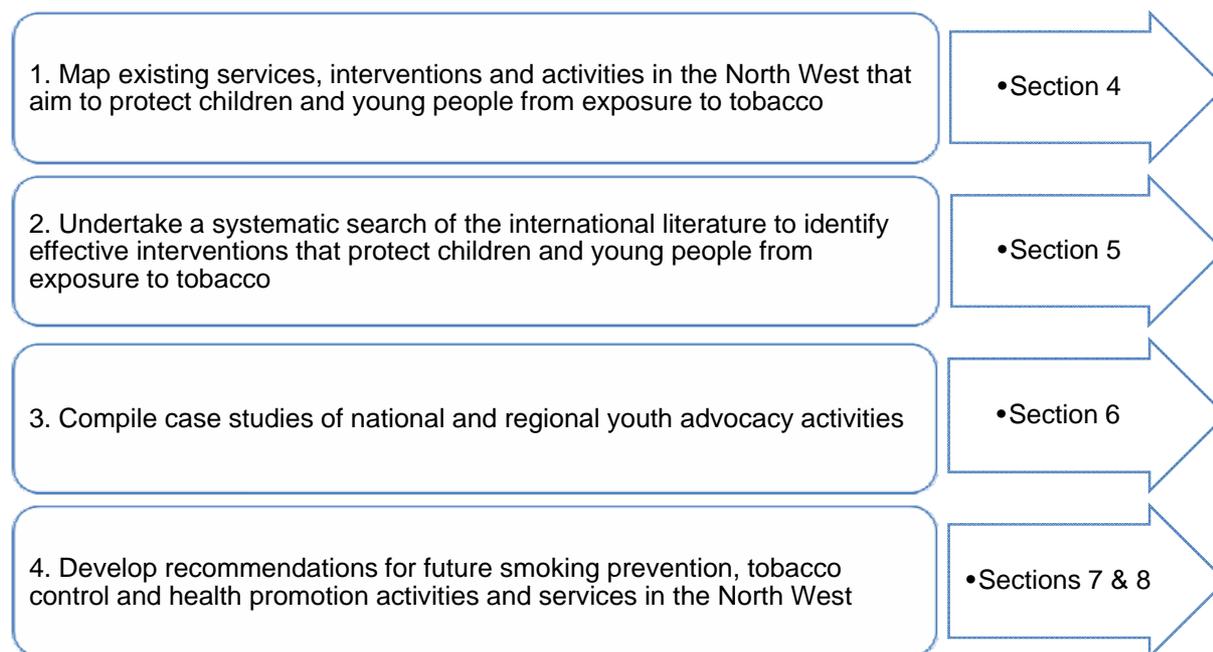
Conclusions

Overall the evidence review and mapping identified that a range of approaches, which both directly and indirectly aim to protect children and young people from exposure to tobacco, are in place across the North West. However, the evidence base for which approaches are most effective is lacking, particularly in relation to smoking cessation. There needs to be evaluation of the effectiveness of programmes at a local and regional level, with an emphasis on the processes involved in service delivery and the outcomes for young people. In addition, systems should be in place to learn from local experience.

1 Introduction

1.1 Aims and objectives

The mapping and evidence review of tobacco control priorities that aim to protect children and young people from exposure to tobacco was undertaken on behalf of Smokefree North West (SFNW) to support the development of future smoking prevention, tobacco control and health promotion activities and services. SFNW is a region-wide initiative to tackle tobacco-related inequalities across the North West. The project sought to meet the following objectives:



2 Background

2.1 Introduction

As the majority of smokers initiate use prior to the age of 18, prevention efforts that target children and young people are essential to prevent uptake and to foster healthy lifestyle choices. Consequently, there has been a concerted effort to target children and young people as a priority group for smoking prevention in the UK, and a range of youth-based health promotion initiatives aimed at preventing or reducing smoking prevalence have been implemented. These include school-based programmes, community-based interventions, mass media and point of sale measures, youth access restrictions and smoking cessation interventions.

At a national level a number of key actions on smoking have been taken by the UK government since the introduction of the Children and Young Persons Act in 1991, and these are summarised in Table 1.

Table 1. Key action by the UK government on smoking since 1991

Year	Legislation	Action
1991	Children and Young Persons (Protection from Tobacco) Act 1991	<ul style="list-style-type: none"> • Increased the penalties for the sale of tobacco to persons under the age of 16 years • Prohibited the sale of unpackaged cigarettes • Required the publication of warning statements in retail premises and on vending machines • Made provision with respect to enforcement action by local authorities
1992	Smoking Kills white paper	<ul style="list-style-type: none"> • Minimal tobacco advertising in shops • Tough enforcement on underage sales and proof of age cards • Voluntary agreement with vending machine operators
1993		
1994		
1995		
1996		
1997		
1998		
1999	Tobacco enforcement protocol	
2000		
2001		
2002	Tobacco advertising and promotion act 2002	<ul style="list-style-type: none"> • Ban on billboard and press advertising
2003		
2004		
2005		
2006	Health Act 2006	<ul style="list-style-type: none"> • SmokeFree legislation banned smoking in public places • Illegal to sell tobacco products to anyone under the age of 18
2007		
2008	Criminal Justice and Immigration Act 2008	<ul style="list-style-type: none"> • Strengthened sanctions against shopkeepers who persistently sell cigarettes to underage children and teenagers

2.2 Smoking among young people in the North West

2.2.1 Smoking prevalence

Although not directly comparable as national and regional surveys are based on different age ranges, smoking prevalence in the North West appears to be higher than national estimates. Nationally, 6% of 11 to 15 year olds in England are regular smokers (defined as smoking at least one cigarette per week) (Fuller, 2008), and a survey of 14 to 17 year olds by Trading Standards in the North West found that 22% claimed to smoke (2007). As shown in Figure 1, there was large variation in rates across the local authorities in the region, ranging from 12% in Knowsley to 34% in Tameside. The percentage of smokers also varied by gender, with 26% of females claiming to smoke compared to 17% of males, and by age, with 19% of 14-15 year olds reporting smoking compared to 25% of 16-17 year olds.

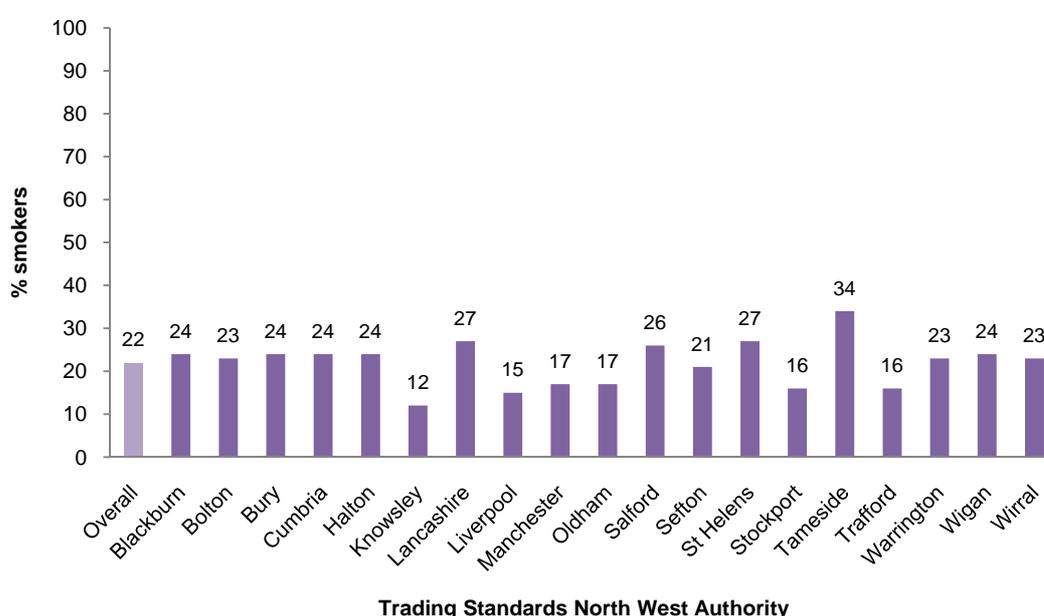


Figure 1. Smoking prevalence among 14-17 year olds in the North West: Trading Standards North West 2007

The national survey of smoking prevalence among young people in England found that the proportion of regular smokers increased from 1% of 11 year olds to 15% of 15 year olds (Fuller, 2008). A survey of young smokers in Liverpool suggests that they have a much younger age of smoking uptake; 13.2% reported being regular smokers at age 11 (Hoshin, 2008). In addition, the survey by Trading Standards in the North West found that 37% of 14-17 year olds claimed to have started smoking at age 12 or younger (Ci Research, 2007), and as shown in Figure 2, all respondents who smoked had begun smoking by the age of 16.

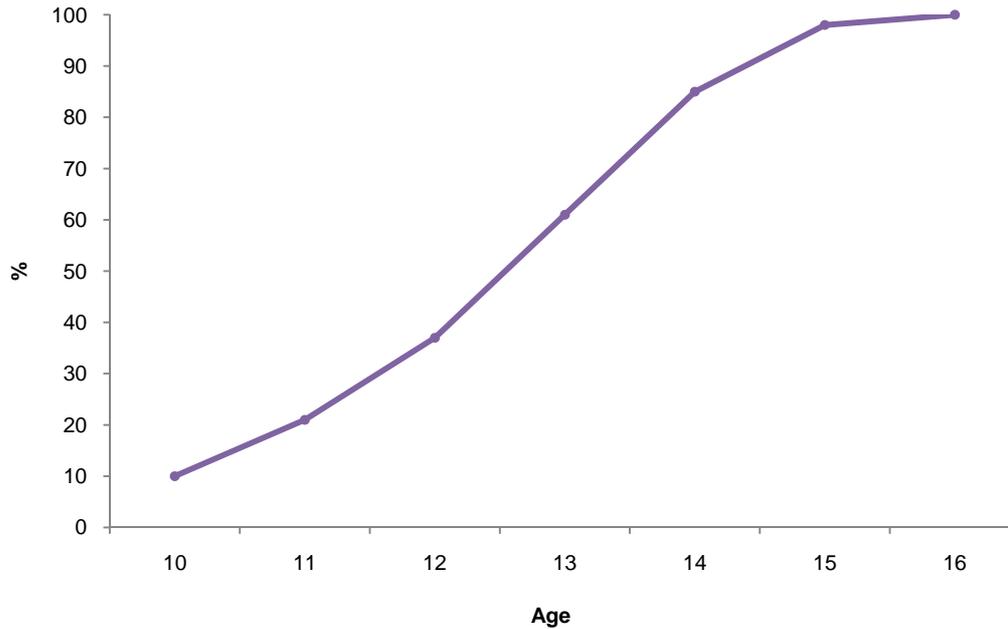


Figure 2. Cumulative percentage of smokers by age: Trading Standards North West 2007

2.2.2 Intentions to quit

Research conducted for DMYST on smoking prevalence among young people in Liverpool aged 11 to 18 found that 53% of smokers in the sample had considered giving up and that 47% had actually made a quit attempt (Hoshin, 2008).

2.2.3 Knowledge and attitudes

A study conducted on Merseyside found that in general, young people had good knowledge of the health effects and law regarding smoking (Woolfall et al., 2008). Regular and non- or ex-smokers were comparable in terms of smoking knowledge. Most of the young people were in agreement that smoking was addictive, was difficult to give up, and that most smokers died younger than non-smokers. There were indications that participants held negative social and cultural perceptions of smoking. Participants also disagreed that smoking was socially advantageous or that smokers were more popular, and the majority believed that smoking represented poor value for money. However, participants who were smokers had significantly more positive attitudes towards smoking than non- or ex-smokers.

2.2.4 Sources of cigarettes among young people

Research conducted in the North West (Ci Research, 2007; Hoshin, 2008; Woolfall et al., 2008) indicates that most young people access tobacco products by purchasing them from shops, such as off licences and newsagents. The Trading Standards survey identified that many young people were obtaining potentially illegal cigarettes or obtaining them from illegitimate sources, and Figure 3 shows the extent of this practice across the North West. A study conducted on Merseyside found that in more deprived areas, young people were purchasing cigarettes from adults who were selling cigarettes from their homes at lower than retail cost (Woolfall et al., 2008). Some young people were aware that they were being sold illegal 'black market' cigarettes and were aware of the associated

health risks; however they felt they had no choice due to access restrictions. Young people are also able to access tobacco products from 'social sources' such as friends, family members and strangers, and a small number report being able to purchase cigarettes from market stalls (Ci Research, 2007; Hoshin, 2008; Woolfall et al., 2008).



Figure 3. Percentage of young people who reported purchasing cigarettes from illegitimate sources: Trading Standards North West 2007

3 Methods

3.1 Mapping

Programmes were identified by contacting organisations and/or networks who deliver services for young people across the 24 Primary Care Trusts (PCTs) and 43 local authorities¹ within the North West (see Figure 4). The mapping sought to identify services or interventions targeted at both adults and children and young people, including smoking prevention, cessation and tobacco control as all have a direct or indirect impact upon young people’s exposure to tobacco. Key contact details for all services were obtained from SFNW as well as through contacts the research team had already established through previous work conducted in this field. In addition, a snowball sampling technique was used where by participants were asked to provide details or forward the request for participation to colleagues in smoking organisations across the North West.

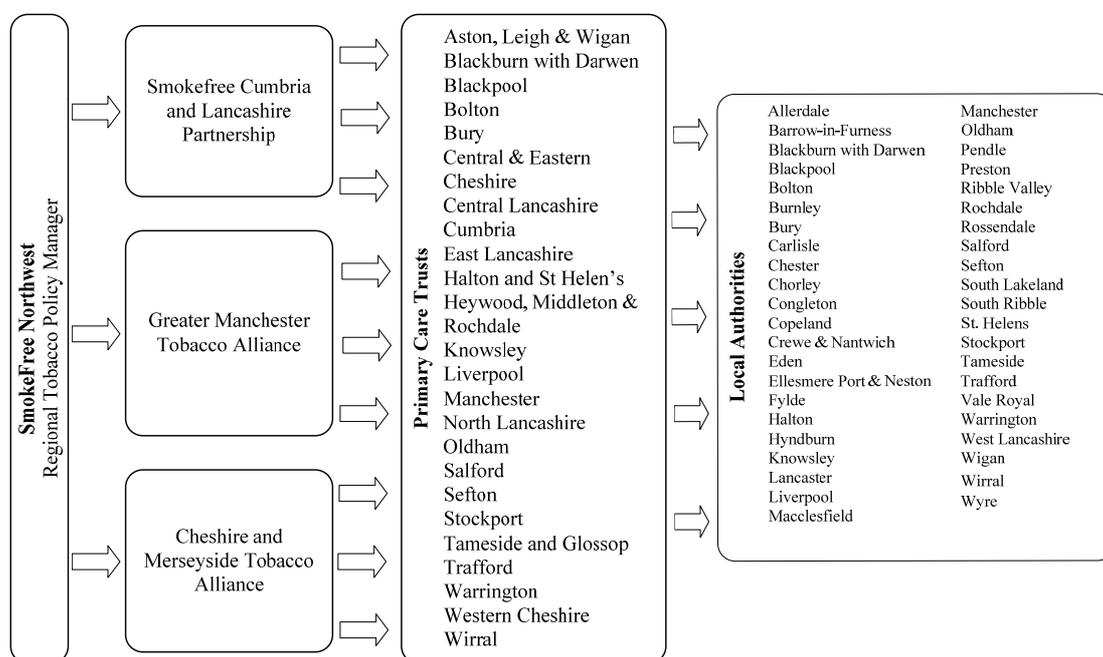


Figure 4. Primary care trusts and local authorities within the North West

A three stage sampling technique was utilised where by questionnaires were distributed by email to key individuals responsible for developing and running smoking related services, interventions and/or activities. Due to limited timelines, an email reminder to all contacts was sent seven days after the initial request. A final attempt to increase the sample size was then conducted seven days later by follow up with a phone call. Extra time was also added to the data collection period in response to requests by participants.

¹ There are 43 lower level local authorities within the North West. Data has been presented at lower level in order to save duplication of data, for example services within Cumbria LA (upper level) are represented as of Carlisle, Eden, Copeland, South Lakeland and Barrow-in-Furness lower level local authorities.

The questionnaire (see Appendix A) was adapted from those used by the team for previous mapping exercises that identified and described service models in the North East of England, Blackburn with Darwen, Cheshire and Merseyside. For each service, intervention or activity the following information was collected: i) lead agency and contact details; ii) aims and objectives; iii) the type of service, intervention or activity delivered; iv) population targeted; v) progress towards key local and national targets; vi) staffing structures; vii) costs and sources of funding; and viii) outcomes from evaluation. Within the questionnaire, participants were also asked to differentiate between advocacy-related and non-advocacy activities. The content of the questionnaire was agreed with Smokefree North West prior to dissemination. Questionnaire data was analysed using the statistical software package SPSS and MapInfo Professional in order to generate basic descriptive statistical data and a map of services by location and against indices of deprivation at lower super output level. Geographical data and technical advice was provided by the North West Public Health Observatory, Liverpool John Moores University.

3.2 Evidence review

The aim of the literature review was to bring together evidence from systematic reviews and meta-analyses that have examined the effectiveness of interventions designed to protect children and young people from exposure to tobacco, including interventions designed to reduce second hand smoke exposure.

A database was compiled from systematic searches of the following electronic sources and websites: The Cochrane Library, MEDLINE, CINAHL, the National Institute for Health and Clinical Excellence, DoPHER (Database of promoting health effectiveness reviews) and the TRIP database. A search strategy was developed using relevant keywords, and where appropriate controlled vocabulary (e.g. MeSH) and search filters developed to find systematic reviews and meta-analyses. Good quality systematic reviews and meta-analyses were included if they meet the following criteria: i) English language; ii) populations of children or young people from developed countries; and iii) published within the last 10 years (i.e. from 1998 onwards). Only good quality systematic reviews and meta-analyses that met the criteria for inclusion on the Database of Systematic Reviews of Effects (DARE) were included.

3.3 Website and grey literature search

The evidence review and mapping were supplemented by a search of the grey literature and the Internet to identify details of relevant national and regional youth advocacy activities that have been conducted since 2007. Relevant advocacy activities included those with overall public health aims and objectives beyond tobacco control. Several strategies were used to identify relevant national and regional advocacy activities including web-based searching of national and regional Smokefree websites and charitable organisation websites (e.g. ASH, The Roy Castle Lung Foundation), consultation with network leads participating in the mapping; and contact with those working in the field.

3.4 Synthesis

A matrix was developed to synthesise the findings of the mapping and evidence review. Key themes arising from the evidence review were tabulated and graded according to the quality of the evidence using a framework for grading evidence and recommendations for public health interventions developed by the Health Development Agency (Weightman et al., 2005). The results of the mapping exercise were presented alongside the key themes arising from the evidence review to give an indication of the range and scope of tobacco control activities in the North West. The matrix was used as the basis for the development of recommendations to support the development of future smoking prevention, tobacco control and health promotion activities and services in the North West.

4 Mapping existing services, interventions and activities in the North West that aim to protect children and young people from exposure to tobacco

4.1 Sample

Data on services, interventions and activities were received from 23 out of 43 (53.4%) North West Local Authorities (LA) and 10 out of the 24 (41%) Primary Care Trusts (PCT). In total, 25 mapping questionnaires were completed with five questionnaires detailing activities that occurred at both LA and PCT level. In some areas (e.g. Sefton and Blackpool) a number of questionnaires were received outlining different interventions and activities run either by the local authority or PCT. Response rates within the three North West Tobacco Alliances were similar, ranging between 50% in both Greater Manchester and the Cumbria and Lancashire alliances and 61% in the Cheshire and Merseyside Tobacco Alliance. All information received is presented in the tables shown in Appendix B. Figure 5 shows a graphical representation of the response rate by lower level local authority area.

It is important to note that the data presented in this section are limited by the level of response from a given area and whether the questionnaires received related to an overview of all activity in an area or to a specific service or intervention. In cases where tobacco related activity in an area related to only one type of intervention (e.g. tobacco control) it is believed that was often due to the level of reporting rather than a lack of differing approaches within a single local authority or PCT. For example, one questionnaire was received from Wigan LA which detailed a school-based smoking prevention intervention. The fact that no other questionnaires were received from this area of the North West does not mean that other activities such as tobacco control or smoking cessation do not exist in the Wigan area.

4.2 Type of service, intervention or activity

All participants were requested to identify whether their service, intervention or activity were focused towards smoking prevention, cessation or tobacco control (or a combination of approaches). Findings demonstrated that a range of approaches, which either directly or indirectly aimed to protect children and young people from exposure to tobacco, were in place across the North West region, these included services for adults, children, young people, pregnant women and programmes that aimed to reduce underage sales of tobacco and enforce smoke free legislation. Examples intervention types included:

Prevention

- School-based education programmes
- Community-based education programmes
- Media campaigns and social marketing
- Youth advocacy

Cessation

- School-based cessation services
- Community-based cessation services
- Smoking cessation for pregnant women

Tobacco control

- Test purchasing
- Smokefree legislation enforcement

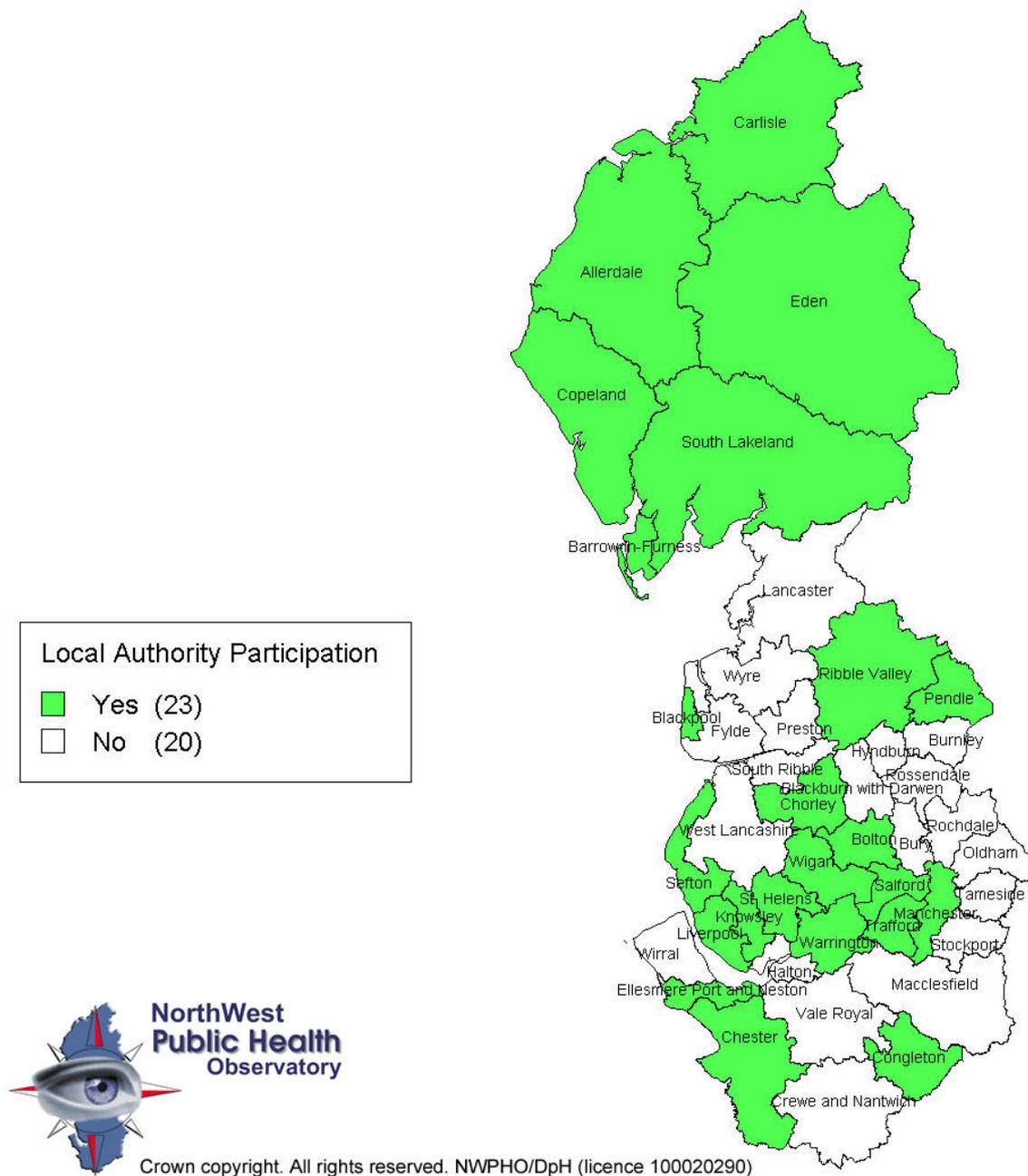


Figure 5. Mapping research participation by local authority

Examples of the services, interventions and activities in place across the region are shown in Table 2 below. (Examples were selected at random. For full details of all activities see Appendix B).

Table 2. Examples of service, intervention or activity by type in the North West

Smoking prevention
<ul style="list-style-type: none"> • School based education programmes <i>e.g. <u>Life Education Programme (Wigan)</u></i> A mobile classroom-based health and drug education programme delivered to primary school children and their parents and carers. This includes raising

awareness among parents and children of the dangers of second hand smoke and the impact parental behaviour can have on children at home or within the wider community.

Smoking cessation

- **Community based stop smoking service**

e.g: Roy Castle Fag Ends (Liverpool and Knowsley). Drop-in stop smoking support groups and one-on-one support providing nicotine replacement therapy (NRT) support (on a voucher scheme). Specialist advisors for vulnerable groups (including young people) and CO level monitoring.

Tobacco Control (Reducing under age sales of tobacco)

- **Test purchasing**

e.g. Underage sale purchasing (Blackpool). Routine test purchasing in Blackpool. Last year (2007-2008), the Blackpool Trading Standards department carried out 20 test-purchasing operations, which included testing at 205 separate retail premises.

Combined approaches

Smoking cessation and prevention

- **School based education and cessation service**

e.g: Trafford School Nursing Service (Trafford). Primary and secondary classroom based education. Anti smoking road shows delivered to secondary schools. One to one cessation advice including voucher scheme for NRT.

e.g. Healthy Schools Drugs Education (Cumbria). A designated co-ordinator works alongside PHSE teachers in both primary and secondary schools across Cumbria providing them with local statistics, information and up-to-date resources regarding smoking which they can use in their personal, social, health and economic wellbeing lessons. The co-ordinator also delivers drug and alcohol awareness sessions, including a session on smoking, for parents and governors in schools.

- **Community based education and cessation service**

e.g: Manchester Stop Smoking Service (Manchester). Smoking cessation support for all people living and working in Manchester with specialist staff developing support for pregnant women, children and young people BME communities and areas of social deprivation. Smokefree Homes Scheme to raise awareness of the dangers of second hand smoke exposure. The service also has a role within school-based tobacco education and young person specific drop in advice clinics.

e.g. Salford and Trafford Stop Smoking Service (Salford and Trafford). Smoking cessation support is based in all GP practices with trained Practice Nurses or Health Care Assistants. An NRT voucher scheme is in operation at the majority of Community Pharmacies with a small number of specialist advisers for primary care, secondary care, workplace and BME communities.

- **Media campaigns and social marketing**

e.g. Sefton Primary Care Trust (Sefton). A range of media campaigns based on the principles of social marketing have been undertaken within the borough to specifically target young people. The content of the campaigns have been developed in partnership with young people and campaigns have been developed to target females and males. A variety of resources have been developed to support the campaigns including bus shelter posters, posters, credit cards and other promotional materials such as pencils.

Smoking prevention and tobacco control

- **Youth advocacy groups**

e.g. DMYST (Liverpool). DMYST is a smoke free movement run by and for young people in Liverpool. DMYST provides young people with an opportunity to air their views and concerns on tobacco and to take action to de-normalise and de-glamorise smoking by raising the awareness of the dangers of tobacco and exposure to second hand smoke amongst other young people; campaigning for and promoting smoke free environments for all and campaigning to get rid of smoking and the placement of tobacco products in the media that is predominantly targeted at young people.

- **Smokefree legislation enforcement and health promotion advice**

e.g. Ribble Valley Borough Council – Environmental Health & Licensing Enforcement (North East Lancashire) Enforcers for smoke free workplace, Health & Safety at Work, support activities of other agencies in reducing use of tobacco – health promotion and licensing enforcement.

e.g. Congleton Borough Council Environmental Health (Congleton). Congleton Borough Council Environmental Health Officers are responsible for the enforcement of Health Act 2006 with regard to tobacco control in premises and vehicles. Environmental Health Officers are also involved in giving talks in schools to pupils regarding the health effects of smoking as part of the Council's work to reduce the incidence of smoking.

Smoking prevention, cessation and tobacco control

- **Community based cessation, school based education and Smoke free home scheme**

e.g. Stop Smoking Service and Tobacco Control (Halton and St Helens). One to one community based smoking cessation support including NRT voucher scheme. Hospital based 'stop before your Op' service, Stop Smoking Service specialist midwives. School based education drama workshop and peer mentoring. Partnership working with Environmental Health and Fire service for a smoke free home scheme.

e.g. Knowsley Tobacco Control Strategy (Knowsley) A community development worker develops projects and training in relation to Smoke Free awareness and targeted interventions on smoke free in community settings with a focus on children, individuals and families. Trading Standards (team) based support around age restricted products with a key focus on tobacco. Retailer Scheme, training and

information awareness. Work with HM Revenues and Customs on illicit tobacco supply. Smoking prevention activity through healthy schools and classroom based education sessions for primary school age children and year 8. Smoking cessation service offers sessional group and one-to-one support to young people in schools.

As shown in Figure 6 and Tables 3 and 4, the majority of tobacco related interventions in the North West deliver a combination of prevention, cessation and tobacco control approaches. The most common type identified was a combination of smoking prevention and cessation (39%), followed by smoking prevention and tobacco control (23%) and all three types (cessation, prevention and tobacco control) (19%).

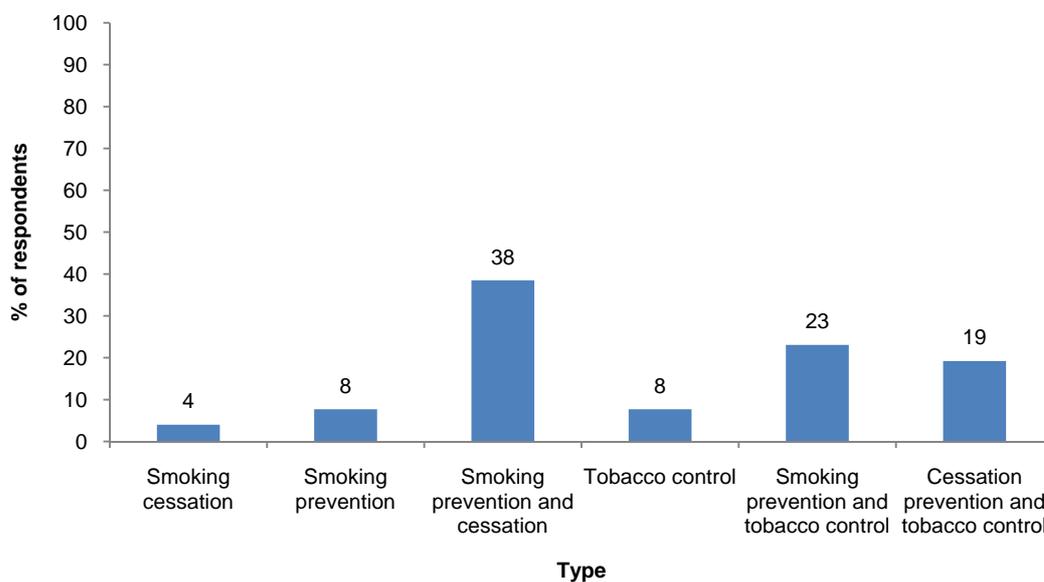


Figure 6. Type of tobacco related service, intervention or activity in the North West

Findings indicated that the majority of participating LAs and PCTs had a range of tobacco related activities that aimed to protect children and young people from exposure to tobacco, with smoking prevention and cessation being the most common combination of reported activity. In terms of specific work that focused on the impact of second hand smoke (SHS), a number of smoke free homes initiatives were being run by the following services:

- Stop Smoking Service and Tobacco Control (Halton & St Helens);
- Sefton Smoke free Homes;
- Salford and Trafford Stop Smoking Service;
- Manchester Stop Smoking Service.

Training and advocacy approaches to raising the awareness of the dangers of tobacco exposure within the home were also in place within interventions such as DMYST (Liverpool) and Knowsley Tobacco Control Strategy.

Tables 3 and 4 provide further detail of the types of activity, services and interventions by local authority² (Table 3) and PCT (Table 4) under each of the three tobacco North West Tobacco Alliances.

Table 3. Activity/service/intervention type by Local Authority and Tobacco Alliance

Tobacco Alliance	Local authority	Activity/service/Intervention type		
		Smoking prevention	Smoking cessation	Tobacco Control
Greater Manchester	Bolton	Yes	Yes	No
	Manchester	Yes	Yes	No
	Salford	Yes	Yes	Yes
	Trafford	Yes	Yes	No
	Wigan	Yes	No	No
Cheshire and Merseyside	Knowsley	Yes	Yes	Yes
	Liverpool	Yes	Yes	Yes
	St Helens	Yes	Yes	Yes
	Sefton	Yes	Yes	No
	Warrington	Yes	Yes	Yes
	Chester	Yes	Yes	Yes
	Congleton	Yes	No	Yes
	Ellesmere Port and Neston	Yes	Yes	Yes
Cumbria and Lancashire	Allerdale	Yes	Yes	Yes
	Barrow-in-Furness	Yes	Yes	Yes
	Blackpool	Yes	Yes	Yes
	Carlisle	Yes	Yes	Yes
	Copeland	Yes	Yes	Yes
	Eden	Yes	Yes	Yes
	South Lakeland	Yes	Yes	Yes
	Chorley	Yes	No	No
	Pendle	Yes	No	Yes
	Ribble Valley	Yes	No	Yes

Table 4. Activity/service/intervention type by PCT and Tobacco Alliance

Tobacco Alliance	PCT	Activity/service/Intervention type		
		Smoking prevention	Smoking cessation	Tobacco Control
Greater Manchester	Bolton	Yes	Yes	No
	Manchester	Yes	Yes	No
	Salford	Yes	Yes	No
	Trafford	Yes	Yes	No
Cheshire and Merseyside	Knowsley	No	Yes	No
	Liverpool	Yes	Yes	Yes
	Halton and St Helens	Yes	Yes	Yes
	Sefton	Yes	Yes	No
	Western Cheshire	Yes	Yes	Yes
Cumbria and Lancashire	Central Lancashire	Yes	No	No

² Some interventions cover more than one local authority and are therefore presented more than once.

As Tables 3 and 4 show, both smoking prevention and cessation activities were reported across the majority of local authority areas and PCTs within each of the three North West Tobacco Alliances. Tobacco control activities were not reported by any local authority or PCT within the Greater Manchester Tobacco Alliance. As stated previously, this is most likely due to under reporting than there being no tobacco control activity in the Greater Manchester area.

4.3 Target population

The majority of participants stated their intervention targeted adults (23%), children (29%) or young people (31%) (see Figure 7). Three participants stated that their intervention targeted just one population; however this was most likely due to lack of reporting. For example, Sefton Smokefree Homes identified themselves as targeting just adult populations when such an intervention would also impact upon children and young people through reduced tobacco exposure in the home. Overall, there were fewer interventions for pregnant women identified (13%) than all other types of tobacco related activity, and the majority of interventions in place for pregnant women provided smoking cessation advice to all adults through a local stop smoking service rather than a specific service targeting pregnant women. Such findings suggest that community-based rather than hospital-based pregnancy interventions were captured in the mapping exercise. Target populations identified as 'other' included retailers, workplaces (n=2) and the tobacco and film industry.

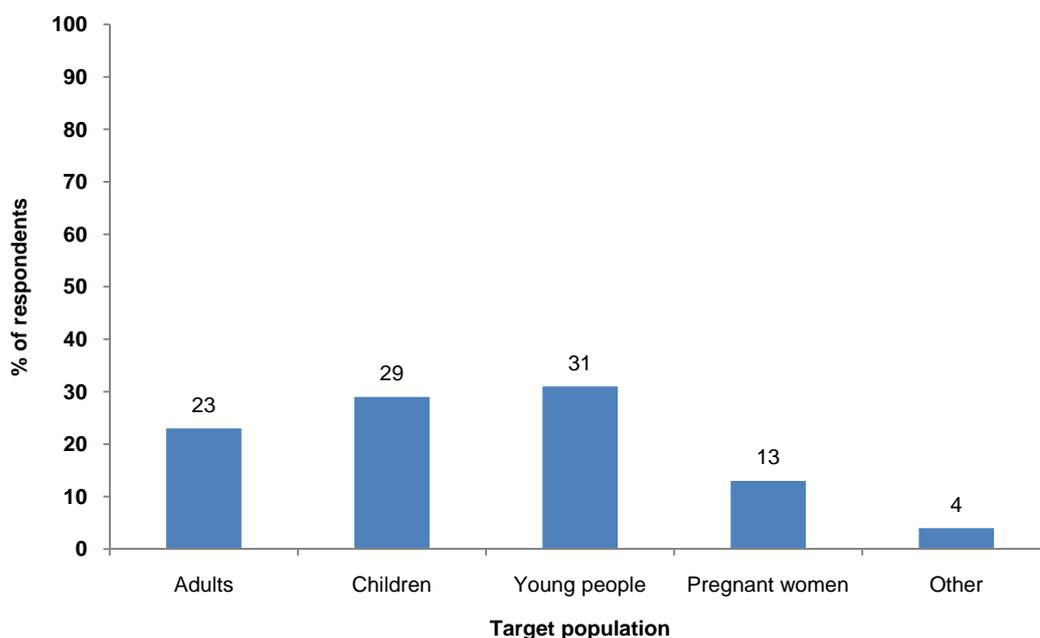


Figure 7. Target population of tobacco related service, intervention or activity in the North West

4.4 Location of delivery

All participants were asked to identify the type of locations where their interventions were delivered and provide full postcode addresses where possible. The majority (72%) of interventions delivered services at a variety of location types. Only 28% were delivered at one type of location, the majority of which (16%) were school based interventions. As shown in Figure 8 below, the most common

locations for tobacco related activities were schools (23%), community centres (15%), GP surgery's/clinics/hospitals (14%), outreach services (14%) and media formats (e.g. Websites, press releases, publicity events) (12%). Less commonly used location types included: church halls (5%), Internet sites (5%) and point of sale (5%). Location types described as 'other' (8%) included workplaces (n=4) and family homes (n=1).

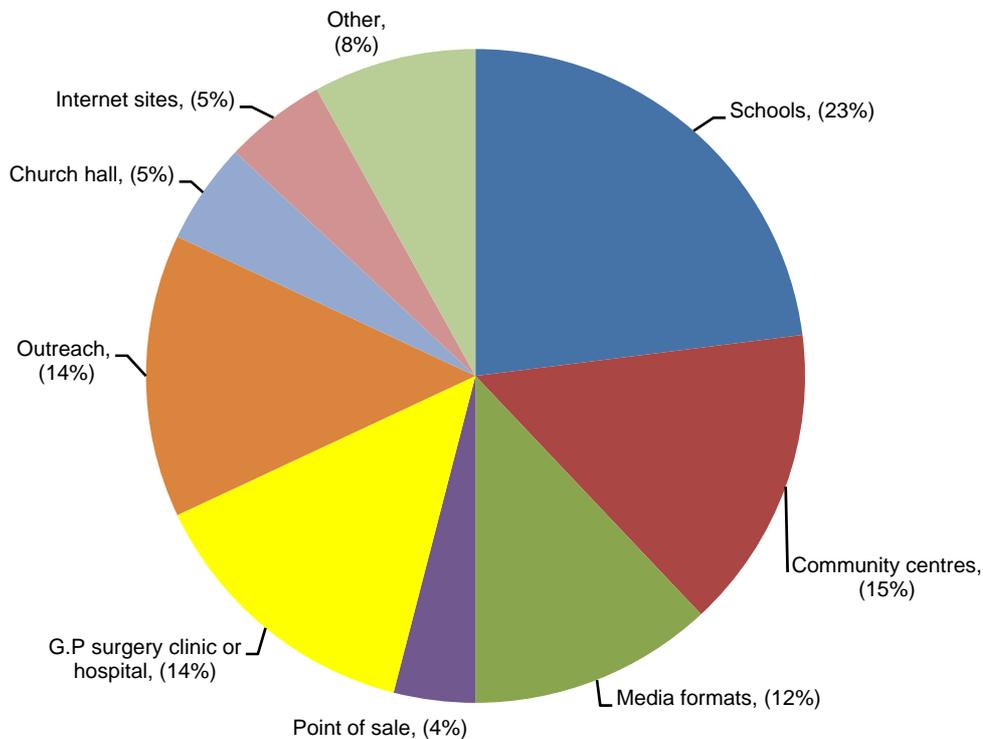
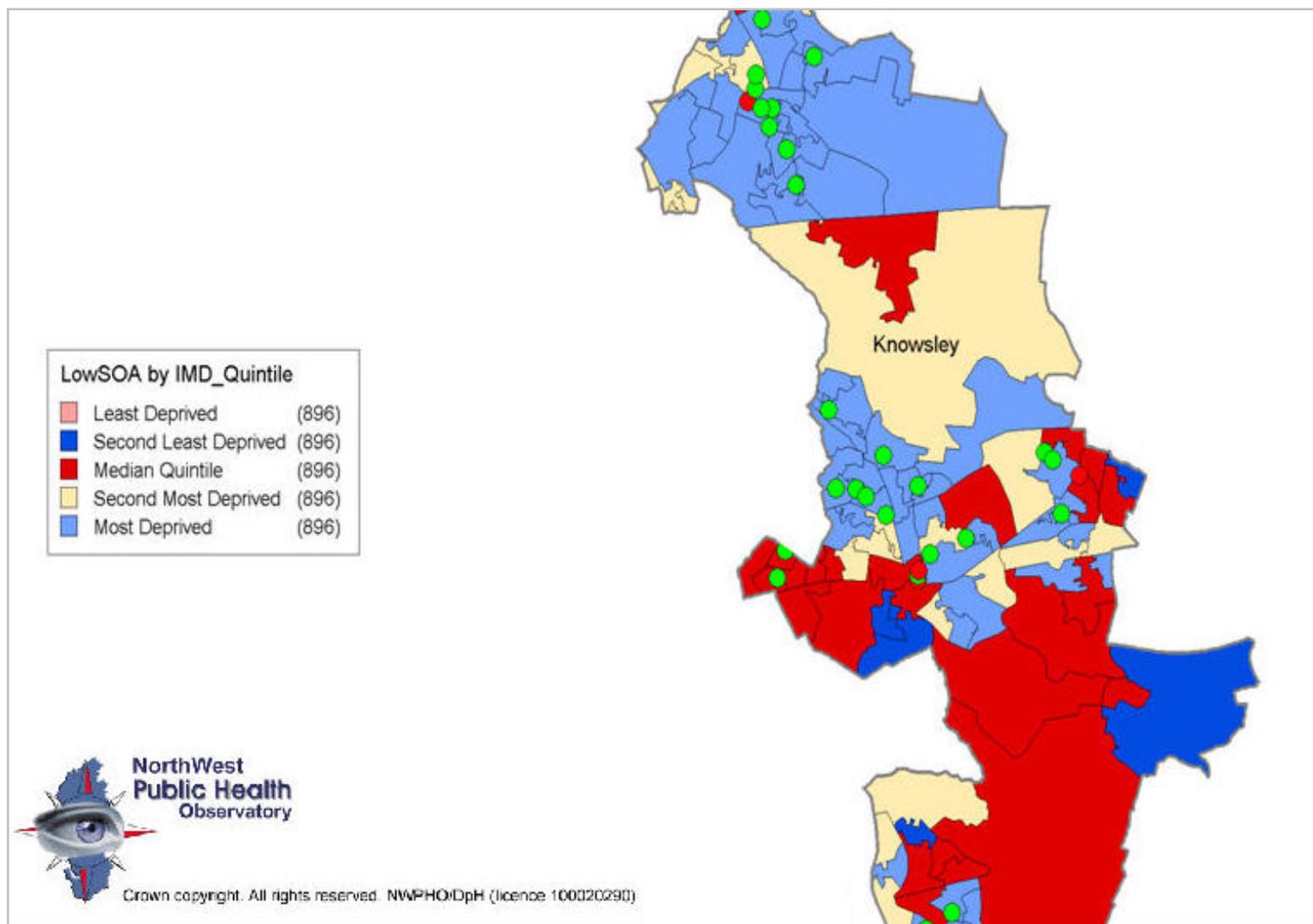


Figure 8. Location of tobacco related service, intervention or activity in the North West

Only five participants provided specific postcodes for the location of their intervention, three of which related to their office base rather than intervention delivery location and have therefore not been included in figures 9, 10 and 11. Many participants stated that they could not provide postcodes as interventions were being delivered across areas rather than in static locations (e.g. test purchasing).

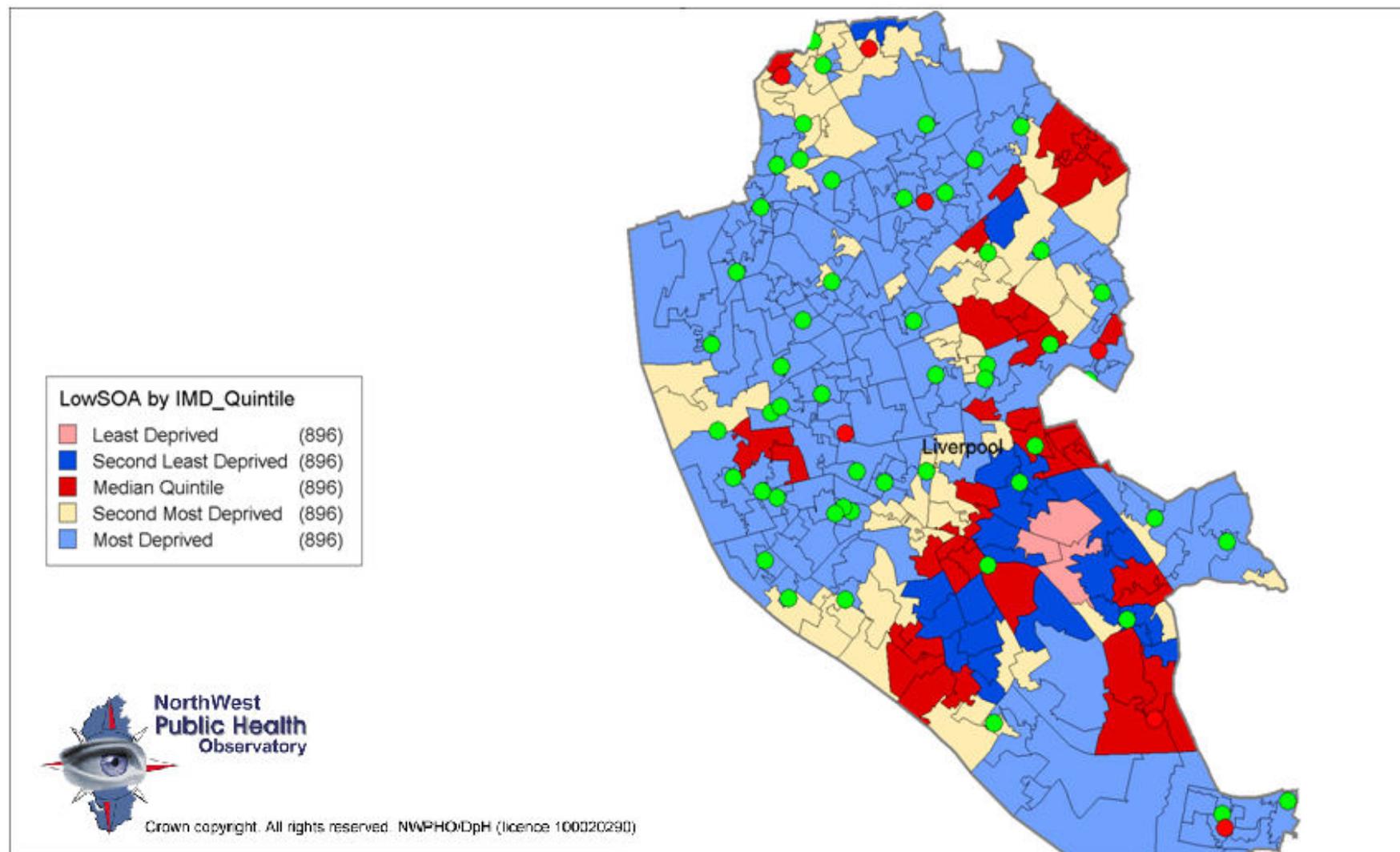
Figures 9, 10 and 11 show the postcode locations for the three interventions that did provide postcode data, these interventions include: Roy Castle Fag Ends (Liverpool & Knowsley) and the Life Education Programme (Wigan). As deaths from smoking have been shown to be higher than average in more deprived localities (Wood et al., 2006), each area presented was matched against *Indices of Deprivation* at super lower output level (Department of Communities and Local Government, 2007) in order to identify where interventions are targeting areas of low, medium or high social deprivation. As Figures 9 and 10 show, the majority of Roy Castle Fag End Services (Group and one-to-one only support) were located in the most deprived areas of Knowsley and Liverpool. The Wigan based Life Education Programme (Figure 11) was located across the Wigan local authority area in areas of low, medium and high deprivation. This reflects the school based nature of this programme rather than

Roy Castle Fag Ends, which specifically targets areas where there is an increased need for smoking cessation services.



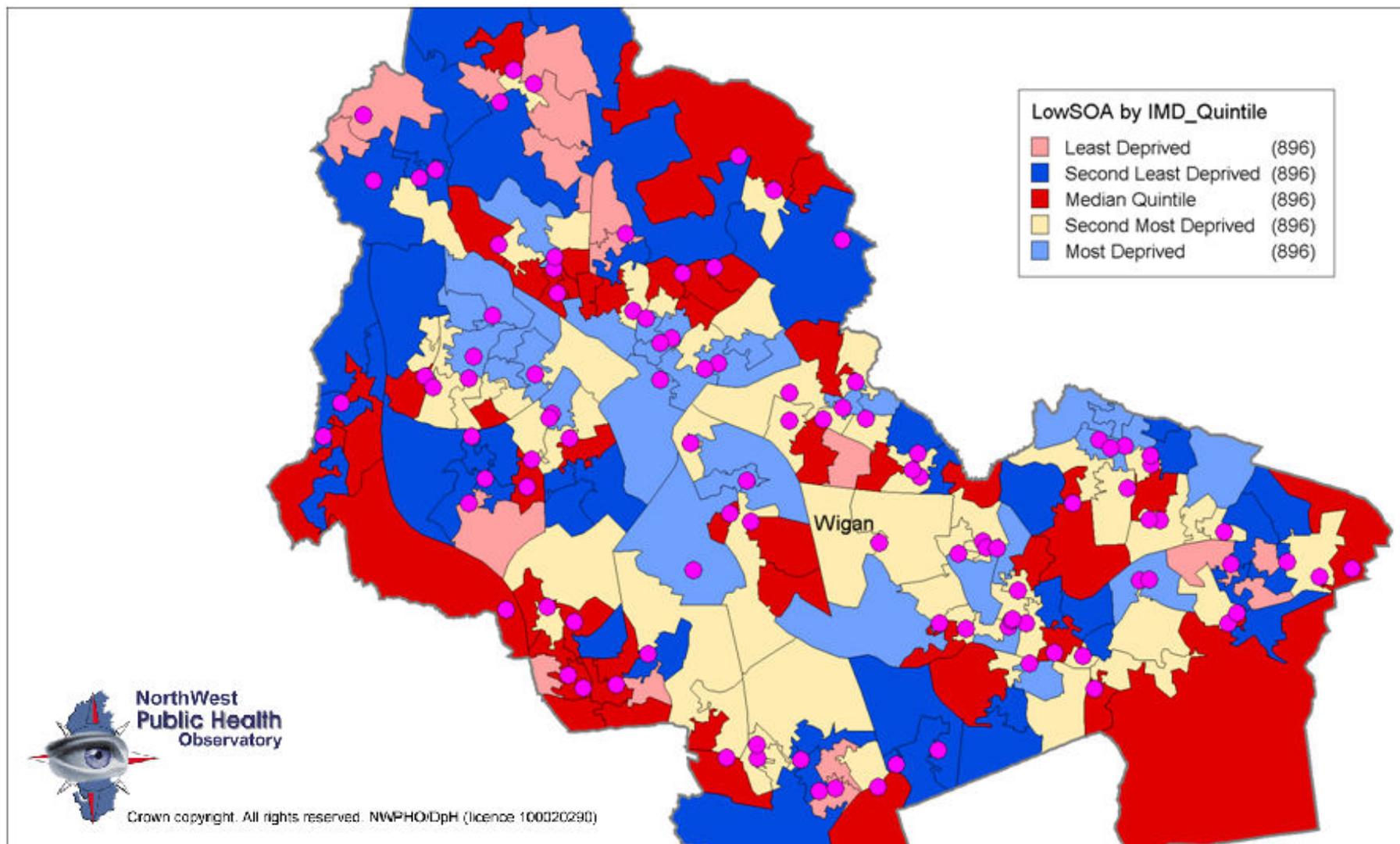
Roy Castle Fag Ends Group = ● One to one = ●

Figure 9: Postcode specific smoking interventions, activities and services in Knowsley



Roy Castle Fag Ends Group = ● One to one = ●

Figure 10: Postcode specific smoking interventions, activities and services in Liverpool



Life education programme = ●

Figure 11: Postcode specific smoking interventions, activities and services in Wigan.

4.5 Monitoring and evaluation: evidence of effectiveness

The majority of participants did provide details of either local and/or national targets against which they were monitoring tobacco related interventions. Tables 5 and 6 detail the local and national targets each participant identified under the type of service being delivered (e.g. smoking cessation and prevention, tobacco control and compliance with smoke free legislation).

Table 5. Local targets interventions are actively monitoring work towards

Target	<i>n</i> (% of total sample)
<i>Smoking cessation and prevention</i>	
Referral to Stop Smoking Service	4 (16)
4- week quitter targets	2 (8)
Number of males/ females accessing service targets	1 (4)
Smoking in pregnancy targets (e.g.2% points per year Vital Sign Target)	3 (12)
75% schools achieving Healthy Schools Status by December 09 (Cumbria)	1(4)
Smoking in young people (girls 2% points Vital Sign Target; boys 1% point Vital Sign Target)	1(4)
Children and Young People's Plan (Every Child Matters)	1(4)
PCT prevalence targets	2 (8)
Nicotine Replacement Therapy Activity	1(4)
Champs Cheshire and Merseyside strategy	1(4)
Commissioning Service Plan	1(4)
Tobacco Control National Support Team Review Findings	1(4)
Local Area Agreement (LAA)	2 (8)
<i>Tobacco Control</i>	
Number of reports submitted for prosecution.	1(4)
Local Area Agreements (LAA)	3 (12)
Trading Standards Business Plan	1(4)
Tobacco Alliance (East Cheshire)	1(4)
Availability of illicit tobacco	1(4)
<i>Compliance with smoke free legislation</i>	
Advocacy	1(4)
Working Neighbourhood Fund targets	1(4)

Table 6. National targets interventions are actively monitoring work towards

Target	<i>n</i> (% of total sample)
<i>Smoking cessation and prevention</i>	
4-Week Quit Target.	6 (24)
Smoking quitters per 100,000 population aged >16 years	1 (4)
PSA target to reduce children smoking to 9% by 2008	1 (4)
Infant inequalities target reduction on smoking in pregnancy	2 (8)
Smoking Kills and Beyond Smoking Kills (policy)	1 (4)
National Indicator 123 16+ <i>current smoking rate prevalence</i>	1 (4)
Public Service Agreement 18 <i>Promote better health and wellbeing for all</i>	1 (4)
National Healthy Schools Standards	3 (12)
SPA (no further details provided)	1 (4)
Department of Health	3 (12)
<i>Tobacco Control</i>	
National average of underage sales	2 (8)
CIEU legislation	1 (4)

As Table 6 shows, there is little commonality in the monitoring of tobacco related services across the North West. At a local level, a broad range of targets were identified, ranging from specific reductions in smoking prevalence rates per population group, to more general references to policy documents (e.g. *Smoking Kills*), the most common targets identified by smoking cessation and prevention services were referrals to Stop Smoking Services (n=4), and smoking in pregnancy targets (n=3) whilst three tobacco control interventions stated that they were monitoring towards Local Area Agreements (Department of Communities and Local Government, 2007). Other monitoring activities identified were service, area or commissioning body specific. Monitoring towards national targets was less evident, although six (24%) smoking cessation and prevention interventions sampled were monitoring their work towards National 4-Week Quit Targets. National Healthy School Standards were identified by three school based smoking prevention and cessation services whilst two tobacco control interventions (8%) were monitoring their work towards National average of underage sales.

4.6 Funding and staffing

From the seven interventions that did provide funding details the following sources of funding were identified:

- Stop Smoking Service budget (n=2)
- PCT (n=2)
- Healthy Schools Core Funding
- Wigan Rotary Club
- County Council

Insufficient data was received to conduct any meaningful analysis of cost or staffing levels. It is felt that the reason for this was due to many participants not knowing specific financial details or choosing

not disclose full financial and staffing information. Where this information was provided details are presented for each intervention in Appendix B.

5 Evidence review

5.1 Introduction

A total of 24 systematic reviews met the criteria for inclusion in the evidence review and supplementary information on each of the included reviews is presented in Appendix G. As shown in Figure 12, the outcomes examined in the evidence review are not independent and the logic framework, developed by Hopkins *et al.* (2001) demonstrates the potential for synergistic progress in tobacco control priorities for children and young people.

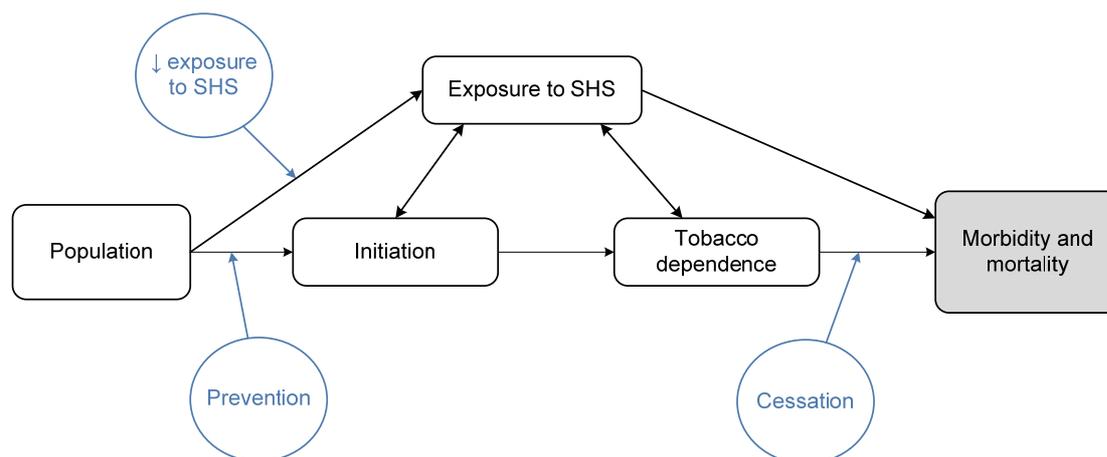


Figure 12. Logic framework adapted from Hopkins *et al.*

5.2 Reducing exposure to second hand smoke

Interventions to reduce exposure to second hand smoke (SHS) have required or encouraged the establishment of smoke-free areas in workplaces, in public areas, and in homes. In 2007, legislation introduced across England banned smoking in enclosed public places and workplaces. However, for infants and children, most SHS exposure occurs within the home (Hopkins *et al.*, 2001) and in cars (Rees and Connolly, 2006). In the UK, an estimated 40% to 60% of children are exposed to SHS in the home (Rushton *et al.*, 2003). Many studies have demonstrated a causal link between exposure to SHS in childhood and chronic middle ear disease (“glue ear”) and sudden infant death syndrome (Cook and Strachan, 1999; Courage, 2002). In addition, children exposed to SHS are more likely to suffer from respiratory illness (bronchitis, pneumonia, cough and wheeze) and to be hospitalised because of their illness than unexposed children (Courage, 2002). Rushton *et al.* (2003) estimated that the percentage of childhood lower respiratory illness and middle ear disease attributable to SHS from either parent smoking ranged from 9% for asthma prevalence and for referral for glue ear, to 25% for hospital admission for lower respiratory illness.

Three systematic reviews (Gehrman and Hovell, 2003; Hopkins *et al.*, 2001; Priest *et al.*, 2008) were identified that examined interventions that aimed to reduce children’s exposure to SHS. A range of interventions have been used to try to reduce exposure to SHS in childhood, and individual studies have reported evidence of success for the following types of interventions: a school-based curriculum approach; an intensive home visiting programme for at-risk mothers that included education about preventive child health; a smoking cessation telephone counselling to mother recruited through 'well

child' clinics; the provision of brief educational information to parents of sick children in a clinical setting; education provided by nurses to mothers attending 'well child' visits about the impact of smoking on either their own or their child's health; and health advice provided to mothers of sick children.(Priest et al., 2008)The authors of the Cochrane review were not able to draw conclusions about which approaches were most effective, however, they found that there is limited support for more intensive counselling interventions delivered to parents. The review by Gehrman and Hovell (2003) also identified that interventions can be effective in reducing children's exposure to SHS. Home-based interventions were highlighted as showing particular promise and the data indicated that interventions delivered in healthy populations may be as efficacious as interventions delivered to sick children. Hopkins *et al.* (2001) concluded that the evidence of effectiveness of education strategies in reducing exposure to SHS in the home was insufficient.

Thomson *et al.* (2006) examined population level policy options for reducing the prevalence of SHS in homes. The only population level option for which the authors found direct evidence of an association with the prevalence of smokefree homes, or evidence of a reduction in inequalities was comprehensive tobacco control programmesⁱⁱⁱ. Indirect evidence suggested that mass media campaigns were a likely means of changing behaviour and social norms on smoking in homes.

5.3 Smoking prevention

Smokers who begin to smoke at a young age are less likely to give up and are likely to smoke more heavily than those who start smoking in later life (Muller, 2007). For example, an American study found that young people who started smoking before the age of 16 were twice as likely to continue smoking compared those who started after age 19 (Khuder et al., 1999). Beginning to smoke in childhood has serious short and long-term health impacts including serious risks to respiratory health (Muller, 2007). In addition, individuals who start to smoke at a young age have higher age-specific cancer rates for all types of tobacco-related cancers (Muller, 2007).

5.3.1 School-based programmes

Schools have been a particular focus of efforts to prevent smoking in young people, particularly in the US (Thomas and Perera, 2006b). Studies of school-based programmes have tended to be based on five types of intervention approaches as identified by Thomas and Perera (2006b) each based on a different theoretical orientation as shown in Box 1.

ⁱⁱⁱDefined as programmes that at a minimum include active tobacco price policies, effective education, smokefree place policies, and population level cessation support.

Box 1: Five types of school-based interventions (Thomas, 2006 #19)

- 1) Information-giving curricula – information about smoking, including health risks of tobacco use, and the prevalence and incidence of smoking.
- 2) Social competence curricula – use cognitive-behavioural skills to teach about generic self-management, personal and social skills such as goal-setting, problem-solving and decision-making. Also teach cognitive skills to resist media and interpersonal influences, to enhance self-esteem, to cope with stress and anxiety, increase assertiveness, and to interact with others.
- 3) Social influence approaches - use normative education methods and anti-tobacco resistance skills training.
- 4) Combined approaches drawing on social competence and social influence approaches
- 5) Multi-modal programmes – combine curricular based approaches with wider initiatives within and outside of school.

Three systematic reviews (Muller-Riemenschneider et al., 2008; Thomas and Perera, 2006b; Wiehe et al., 2005) were identified that examined the effectiveness of school-based programmes for the prevention of smoking. The majority of studies that have examined school-based intervention to prevent smoking are based on social influences approaches and although there is evidence that these programmes may reduce smoking uptake in the short term, there is conflicting evidence about the long term effectiveness of these programmes (Muller-Riemenschneider et al., 2008; Thomas and Perera, 2006b; Wiehe et al., 2005). There was limited evidence for the effects of other approaches, including developing generic social competence and multi-modal programmes.

Researchers have examined other approaches to smoking prevention within the school setting. In a systematic review of incentive schemes to encourage positive health behaviours, Kavanagh and colleagues (2006) pooled the results from two studies of school-based anti-smoking competitions. The results of these studies showed that the intervention had a positive impact on daily smoking rates at one year (RR 1.05; 95% CI 1.02, 1.08). However the authors caution that these findings may be limited by the small sample size and reliance on self-report data. In the ASSIST trial, Campbell *et al.* (2008) examined the effectiveness of a peer-led approach, which aimed to spread and sustain new norms of non-smoking behaviour through social networks in schools. Influential year 8 students (aged 12-13 years) were trained to act as peer supporters during informal interactions outside of the classroom, such as during breaks and at lunchtime, to encourage their peers not to smoke. Across 59 schools, the intervention was effective in achievement of a sustained reduction in the uptake of regular smoking in adolescents up to two years after delivery (OR 0.78; 95% CI 0.64, 0.96).

Research has also shown that a whole school approach may be important in preventing smoking uptake in young people. A systematic review by Fletcher *et al.* (2008) found that action to improve school ethos and support student engagement can have positive effects on students' drug use including smoking, and should be viewed as a promising complement to curriculum-based interventions.

5.3.2 Community-based programmes

Researchers have recognised that decisions to smoke are made within a broad social context and this has led to the development and implementation of community-based programmes (Sowden and Stead, 2003). Three reviews (Bruce and van Teijlingen, 1999; Christakis et al., 2003; Sowden and Stead, 2003) were identified that examined community-based smoking prevention interventions. Sowden and Stead (2003) undertook a systematic review to assess the effectiveness of community interventions in preventing the uptake of smoking in young people, Bruce and van Teijlingen (1999) examined the effectiveness of UK and Irish Smokebusters clubs, and Christakis *et al.* (2003) examined smoking prevention interventions delivered in primary care and dental settings.

There is limited support for the effectiveness of multicomponent community-based interventions for preventing the uptake of smoking (Sowden and Stead, 2003). Two studies, which were part of larger, cardiovascular disease prevention programmes aimed at entire populations (Perry et al., 1994; Vartiainen et al., 1998), demonstrated effectiveness. Both programmes included a school-based component specifically targeting young people. A three-year, comprehensive community-wide intervention that included media advocacy, anti-tobacco activities, family communications and initiatives aimed at reducing youth access to tobacco was shown to be more effective than school-based intervention alone (Biglan et al., 2000). Currently, there is insufficient evidence to determine whether Smokebusters clubs are effective in terms of reducing smoking, although there is evidence that the programme may improve childhood knowledge and awareness of the hazards of smoking (Bruce and van Teijlingen, 1999). There is limited evidence for the effectiveness of prevention interventions delivered in primary care and dental settings (Christakis et al., 2003). One UK study (Fidler and Lambert, 2001), in which children between the ages of 10 and 15 years were sent smoking prevention material every 3 months, demonstrated a small but significant reduction in smoking.

5.3.3 Family-based programmes

A number of studies have demonstrated that smoking amongst parents and older siblings is predictive of smoking amongst young people. For example, Bricker *et al.* (2006) found that family smoking influences both initiation and escalation of children's smoking. If one parent in the family smoked, there was a 32% chance that their children would have tried smoking by age 8-9 years. In addition, both parenting style and smoking-specific parenting practices can have effects on smoking in young people (Chassin et al., 2005).

Two reviews were identified that examined the effectiveness of family-based and parenting programmes for preventing smoking (Petrie et al., 2007; Thomas et al., 2007). Both reviews identified that family-based interventions have tended to be complex interventions, of which the parenting programme was only one component. The majority of studies examined focused on other health behaviours in addition to tobacco such as alcohol and drug use. Currently, a strong evidence base for the effectiveness of family-based interventions is lacking, however, how well the programme staff who delivered the intervention are trained and how well they delivered the intervention appears to be related to effectiveness (Thomas et al., 2007). Promising intervention approaches identified include

the Iowa Strengthening Families Programme (ISFP) (Spoth et al., 2001), which focused on strengthening parenting skills, and the Family-School Partnership (Storr et al., 2002), which focused on building partnerships between parents and the school.

5.3.4 Mass media interventions

Mass media strategies have been used for broad based public education regarding a variety of public health issues, including tobacco use prevention and control (Lantz et al., 2000). Mass media efforts may be viewed as particularly appropriate for delivering anti-smoking messages to young people, as they are often heavily exposed to and greatly interested in the media (Sowden, 1998).

There is some evidence that mass media campaigns can be effective in preventing the uptake of smoking in young people (Sowden, 1998), particularly when combined with other intervention approaches (Hopkins et al., 2001). Successful campaigns were longer in duration and more intense than unsuccessful campaigns, and message content has been shown to influence the effectiveness (Richardson et al., 2007). Sowden (1998) highlighted the need to carry out developmental work with representative samples of the target audience prior to intervention delivery and that campaign messages should be guided by theoretical concepts about how behaviours are acquired and maintained. Preferences for different media formats is likely to depend on age (Sowden, 1998), but studies indicate that television adverts may be recalled more frequently than other formats (Richardson et al., 2007).

A review of mass-media campaigns delivered in the USA (Friend and Levy, 2002), found that well-funded and implemented mass-media campaigns targeted at the general population and implemented at the state level, in conjunction with tobacco control programmes were associated with reduced smoking rates. In agreement with other reviews of mass media interventions, Friend and Levy (2002) found that campaigns of longer duration and higher intensity appeared to be associated with greater declines in smoking rates.

5.3.5 Advocacy

Chapman (2007) describes public health advocacy as a broad process that seeks to bridge the gap between what is being implemented in public health and what those in the field know would make a difference, he states that "it is critical that advocacy is understood to be a *strategy*, and not as an end in itself". A review of the evidence for advocacy as a health promotion strategy concluded that currently the evidence base is weak (McCubbin et al., 2001). However, Chapman highlights "efforts to attribute causal effects from advocacy processes to their outcome objectives are fraught with problems" (Chapman, 2007). Sparks (2007), who reviewed the evidence on advocacy as a tobacco control strategy, concluded that a comprehensive approach to tobacco control focusing on policy advocacy has resulted in many policy changes for tobacco control that have in turn had an effect on smoking prevalence. The impact of advocacy initiatives will be further examined in a subsequent review to be conducted for Smokefree North West in the first quarter of 2009.

Case studies of regional and national youth advocacy activities for tobacco control are presented in Section 6.

5.4 Smoking cessation for children and young people

Studies that have assessed the prevalence of self initiated cessation among adolescents have found them to be relatively low (Mermelstein, 2003). For example, in a longitudinal study of Australian youth (Stanton et al., 1996), at age 18 only 5% of those who were daily smokers at age 15 had not smoked in the past month, although the majority had tried to quit (81%). One reason why adolescents may not readily stop smoking is that they may be dependent on nicotine, even before they become regular or daily smokers (Mermelstein, 2003).

Research regarding smoking cessation interventions for adolescents is at an early stage (Grimshaw and Stanton, 2006; Mermelstein, 2003). Three reviews (Garrison et al., 2003; Grimshaw and Stanton, 2006; Sussman et al., 2006) were identified that examined the effectiveness of a broad range of smoking cessation interventions for young people. Interventions which have demonstrated effectiveness are complex and designed to respond to the many issues that characterise young peoples' smoking, in particular programmes based on motivational enhancement, cognitive-behavioural therapy and the transtheoretical model of change have demonstrated success (Grimshaw and Stanton, 2006; Sussman et al., 2006). In terms of setting, programmes delivered in classroom and school clinic settings have produced significant effects (Sussman et al., 2006). Few studies have examined pharmacological approaches to cessation with young people, and of those studies that have, the results for the effectiveness of nicotine replacement therapy (NRT) (patch or gum), and bupropion (Zyban) as an adjunct to NRT, are inconclusive (Grimshaw and Stanton, 2006). A recent study (Rubinstein et al., 2008), that examined the feasibility and utility of using nicotine nasal spray (NNS) for adolescent smokers aged 15-18 years concluded that the study did not support the use of NNS as an adjunct to counselling because of the unpleasant side effects, poor adherence and lack of efficacy. Muramoto *et al.* (2007) found that a 6-week course of sustained-release bupropion hydrochloride at a dose of 300 mg per day in addition to brief counselling demonstrated short term efficacy (6 weeks) in adolescents aged 14-17 years, whereas 150 mg per day did not result in increased quit rates.

An evaluation of eight youth cessation pilot programmes in Scotland provides little support to the case for developing dedicated youth cessation services (Gnich et al., 2008). The study found that considerable time and effort were required to attract young smokers to services and that intervention resulted in a disappointing overall quit rate. At 12-months follow-up, 8.1% of participants reported that they had quit (Gnich et al., 2008). Studies of adolescent preferences for smoking cessation services have identified that current models of provision may not meet the needs of young smokers (MacDonald et al., 2007; Porcellato, 2008). Young smokers have expressed a preference for flexible support, organised around friendship groups, and may be reluctant to seek help from traditional providers; expressing a preference for non-school based services.

5.5 Smoking cessation for pregnant women

Smoking cessation programmes for pregnant women have been shown to significantly reduce smoking rates (Lumley et al., 2004). A Cochrane review by Lumley *et al.* (2004) examined a broad range of intervention approaches including cognitive behavioural therapy, individualised advice and

support based on 'stages of change' theory, NRT and rewards and incentives. Most trials included in the review were classified as cognitive behavioural and this group of studies provided the clearest evidence of effectiveness. Naughton et al. (2008) examined self-help interventions for pregnant smokers. Self-help interventions (including booklets, videos, and written prescriptions and letters of encouragement from health professionals) were found to be more effective than usual care (OR 1.67; 95% CI 1.14, 2.44), which generally consisted of routine advice to quit smoking and the provision of brief written materials. However, there was no evidence that interventions materials of greater intensity were significantly more effective than materials of a lesser intensity (OR 1.25; 95% CI: 0.81, 1.94). Dennis and Kingston (2008) found that telephone support as a primary intervention had no overall effects on smoking abstinence, relapse or cessation among pregnant women. However, a small number of studies indicated that telephone support in combination with home visits or other face-to-face sessions may have a beneficial effect on smoking abstinence and relapse. Levitt *et al.* (2007) found no effect of postpartum interventions, which included advice materials and counselling interventions in hospital, paediatricians' offices, or child health centres, on relapse prevention, cessation rates or smoking reduction.

5.6 Reducing underage access to tobacco

The main intervention approaches that have been examined for reducing underage access to tobacco include education about legal requirements, notification of the results of compliance checks, and warnings of enforcement by police or health officials (Stead and Lancaster, 2005). Successful interventions have used a variety of strategies, including personal visits and mobilising community support. In addition, enforcement, or warnings of enforcement, had been shown to have some effect on retailer behaviour but sustaining compliance requires regular enforcement (e.g. 4-6 times a year). Multi-faceted interventions are most effective for reducing youth access to tobacco, particularly when combined with ongoing enforcement, and law enforcement or multi-component education programs are more effective than informing retailers of minimum age restrictions (Richardson et al., 2007). Stead and Lancaster (2005) noted that enforcement may produce a backlash against tobacco control activities if the value of reducing sales has not been adequately publicised within the community. Evidence suggests that vending machine policies are most effective at reducing youth access to tobacco when combined with locking devices or complete vending machine bans (Richardson et al., 2007). The success of access restrictions may be impeded by youths' ability to access tobacco products from social sources (e.g. friends, siblings, parents and private sellers) (Richardson et al., 2007).

6 Regional and national youth advocacy activities

6.1 Introduction

Advocacy has been increasingly used as a public health intervention strategy to reduce tobacco use (Sparks, 2007), and the SFNW Action Plan for 2008-09 includes a specific focus on national and regional advocacy activities for tobacco control. In order to achieve the objective to review and document details of national and regional youth advocacy activities, case studies were compiled for youth advocacy groups identified through the mapping, and grey literature and internet searches.

6.2 Regional activities

A number of youth advocacy groups in various stages of development were identified. The most well established advocacy initiatives in the North West, DMYST (Direct Movement by the Youth Smokefree Team) and the Roy Castle Foundation Anti-Tobacco Youth Campaign (ATYC), are based in Liverpool and were launched prior to 2007. Since then the ATYC have worked in partnership with PCT's and youth services to set up similar groups across the North West, and currently there are groups which have or are being established in the following areas:

- Cumbria;
- Bolton (Bolton Kids Against Tobacco);
- Bury;
- Rochdale
- Salford (STAMP); and
- Western Cheshire.

Requests for further information were sent to contacts at each of these regional initiatives, and replies were received from the ATYC, D-MYST, Bolton Kids Against Tobacco and Western Cheshire PCT. Case studies for each of these initiatives are presented below.

BKATS (Bolton Kids Against Tobacco Smoke)

Lesley Jones, Health Improvement Practitioner

Aims and objectives

BKATS is a tobacco education project aimed at primary school aged children. It will be a programme of three lessons looking at general knowledge about tobacco and smoking, the health risks caused by smoking and peer pressure.

The project is also developing a website to support the project and a pack of materials for children to be given out once the lessons have been completed.

Activities

The project began with a competition for children to design a character to represent the project. The team are currently working with a primary school to develop an education programme, and resources and materials to support the website.

Funding Public health monies.

Anti-Tobacco Youth Campaign (ATYC)

Lisa Gill, Youth Project Manager, Roy Castle Lung Cancer Foundation

Aims and objectives

ATYC aims to give young people a voice, knowledge and skills to campaign about smoking and tobacco issues so that young people feel equipped to influence the social, political and economic culture and environment in which they live. to encourage young people individually and collectively at local, national and international levels to join the campaign

Objectives:

- to provide information and support to young people on tobacco related issues, including quitting smoking
- to consult with young people on the direction of the campaign, and work with them on developing the approach and tactics
- to consult with young people on the design, content, production and distribution of resources

Activities

Initially when ATYC groups are set up we deliver training to equip the young people with the skills and knowledge to take their campaign forward. Training covered includes tobacco control (including tobacco production and advertising), presentation and debating skills, campaigning and lobbying and peer education. As the projects develop, if young people identify further training, we will endeavour to arrange this.

Activities to date:

- 236 young people have received structured training (May 06 – April 08);
- Petition about smoking on public transport;
- Signed Everton FC and Manchester United FC to the campaign;
- Two ATYC groups attended BAT AGM events in partnership with ASH;
- Produced DVD/ documentary in partnership with Salford ATYC group STA-MP;
- Various materials produced by young people including awareness raising re raising the legal age limit to purchase tobacco and second-hand smoke in the home;
- Consultation regarding the Department of Health 'Hooked' advert, pictorial warnings on tobacco products ;
- Won "Places for Players" which involved press conference with Liverpool FC players
- Interviewed Darius Danesh regarding smoking in musicals and theatre;
- Supported DMYST in their campaigns;
- Provided young people focus groups for NICE guidance regarding smoking in schools and smoking during pregnancy;
- Delivered workshop at European Parliament, Brussels in partnership with Hope St Healthy Arts;
- Presentations at various conferences for health professionals, Cherie Booth QC and youth organisations encouraging other young people to get involved;
- Developed interactive website in continuing consultation with young people including ageing game;
- Throughout the programme young people have done various media interviews with the BBC and SKY News about their activity and work;
- Plans for the future include taking six young people to Brussels with SFNW to meet with Members of the European Parliament;
- Produce best practice resource on youth advocacy.

The ATYC continue to work with the groups across the region on their own tobacco control agendas – ATYC are currently working with groups in Liverpool, Salford, Cumbria and Rochdale and developing groups across Western Cheshire.

Western Cheshire PCT

Alison Paul, Tobacco Control Manager

The PCT and partner agencies are working with the ATYC to develop three advocacy groups for young people in the area. We are currently finding groups where we can engage with young people targeting areas where there is greater need. The groups focus on the issues surrounding tobacco not just smoking cessation. Currently one group is tentatively starting and the other two are being identified. We are optimistic these groups will build interest from our children and young people in the wider aspects of tobacco.

D-MYST

Danielle Maloney, (Acting) D-MYST Programme Manager

Aims and objectives

DMYST is a smokefree movement run by and for young people in Liverpool. DMYST provides young people with an opportunity to air their views and concerns on tobacco and to take action to de-normalise and de-glamorise smoking by:

- Raising the awareness of the dangers of tobacco and exposure to second-hand smoke amongst other young people
- Campaigning for and promoting smokefree environments for all
- Campaigning to get rid of smoking and the placement of tobacco products in the media that is predominantly targeted a young people.

The campaign is pro smokefree, anti-tobacco, anti-industry and not anti-smoker.

Activities

SmokeFree Stadia campaign: In 2006, D-MYST launched their campaign with the aim of making Everton and Liverpool FC's stadiums 100% smokefree. DMYST dedicated their summer holidays to the smokefree stadia campaign by attending events across the city and asking people to signing up and support smokefree stadiums. More than 8000 people signed the petition in support which D-MYST presented at Anfield stadium. As a result of the campaign not only were D-MYST mentioned in the DoH consultation response but when the smokefree legislation came into place on the 1st of July 2007 all stadiums were declared smokefree.

SmokeFree 'Scary Movies' campaign: This campaign, which aims to remove smoking from youth rated films is a result of D-MYST'S Toxic Movies campaign which was launched in 2007. With no response from the BBFC regarding letters from people across Liverpool; D-MYST asked for a meeting to discuss smoking in movies and how they are regulated, but were refused. To highlight the issue D-MYST held an International SmokeFree Movies conference in Liverpool. Following on from this the SmokeFree 'Scary Movies' campaign was launched in partnership with SmokeFree Liverpool. SmokeFree Movies is now asking the BBFC to recognise that smoking in films is an important issue, and then to use its existing powers to prevent smoking images being shown in newly classified films which can be seen by under-18s.

Funding The Working Neighbourhoods Fund

6.3 National activities

No advocacy initiatives for young people were identified that are national in scope. However, youth advocacy groups that have or are being developed were identified in Wales and in Scotland. Ffaith is a youth advocacy project run by ASH Wales that was launched in October 2007. The programme was initially piloted in five areas of South Wales, but ASH Wales recently applied for funding to continue the programme. NHS Greater Glasgow and Clyde are currently in the early stages of establishing a youth advocacy group, and have received support from DMYST to achieve this aim. Case studies are presented for each of these initiatives.

NHS Greater Glasgow and Clyde

Sarah Lindsay, Health Improvement Senior (Tobacco and Young People)

Aims and objectives

The aims and objectives are under development. The main focus has been to develop a group of interested young people to lead on elements of tobacco control that they feel are relevant

Activities

Young people were recruited to the group in October 2008 and meet once a month. They have had two meetings so far, with a focus on brand development while at the same time using activities to increase young people's knowledge of tobacco control issues so that they can choose issues to work on which are relevant to them. The group has received support from DMYST to develop a recruitment campaign and to run a two day launch and training event.

Funding NHS Greater Glasgow and Clyde

Ffaith programme

Daniel Clayton, Youth Health Promotion Specialist, ASH Wales

Aims and objectives

The aim of the Ffaith programme is to reduce the acceptability and use of tobacco products by young people across Wales such that tobacco use becomes undesirable and unacceptable. Ffaith will do this by working with young people to develop a peer led, social marketing tobacco control strategy.

The outcomes of the Ffaith programme are as follows:

1. 70% of young people engaged as advocates in the Ffaith programme will demonstrate improved knowledge about tobacco and decreased acceptance of tobacco use over the life of the programme
2. 70% of young people engaged as advocates in the Ffaith programme will report improved self esteem and self efficacy such that they are able to engage more productively in their communities over the life of the programme
3. By the end of the programme 60% of young people who use the adolescent cessation model developed by the Ffaith programme will report satisfaction with the service.
4. To achieve an increase of 10% year on year for the life of the programme of advertising value equivalent for the Ffaith campaign such that Ffaith is a readily identifiable and acceptable brand signifying youth resistance to tobacco.

Activities

Over the course of the pilot Ffaith ran many campaigns and cessation groups. Further details of which will be expanded upon with the launch of the final report.

Funding Pilot (Oct 2007 – Dec 2008) was funded by Pfizer foundation. Ffaith are currently awaiting approval for funding from Big Lottery for three years worth of funding

6.4 Non-tobacco control specific youth advocacy groups

Details of two national youth organisations for young people were identified, the British Youth Council and the UK Youth-based "Voice".

The British Youth Council (BYC) is an organisation of young people for young people across the UK, which provides a range of services to develop and support youth-led member organisations. However the BYC youth manifesto for 2008-09⁴ does not currently include a policy on smoking. BYC local youth councils are located across the North West and a list of councils identified via the BYC website is provided in Appendix H.

Voice is a youth led organisation within UK Youth that is "dedicated to giving 16-25 year olds a voice". The Voice Panel is made up of two young people from each region of England, one young person from the Channel Islands, and two young people from Scotland, Wales and Northern Ireland. Voice is a key part of UK Youth's network and is seen as a model of good practice in the field of youth participation. Voice Term 2008-09 resolutions include knife and gun crime, parenting, the health service, and UK youth services.

⁴ www.byc.org.uk/asset_store/documents/british_youth_council_youth_manifesto_2008-09.pdf

7 Synthesis

Table 7. Mapping and evidence review matrix

Intervention	Nature of evidence	Level of evidence	Interventions in NW n (%)	Areas (LA) of NW covered
Reducing exposure to second hand smoke	<ul style="list-style-type: none"> A range of intervention approaches have been used to try to reduce exposure to SHS in childhood; <ul style="list-style-type: none"> There is limited support for more intensive counselling interventions delivered to parents; Home-based interventions may be particularly promising; Interventions delivered in healthy populations may be as efficacious as interventions delivered to sick children. 	1+	25 (100) ^v	All participating LAs (23)
	<ul style="list-style-type: none"> Comprehensive tobacco control programmes, that at a minimum include active tobacco price policies, effective education, smokefree place policies, and population level cessation support, are associated with increases in the prevalence of smoke-free homes. 	2+	5 (20) ^{vi}	Chester, Ellesmere Port & Neston, Halton, St Helens, Liverpool, Warrington
Smoking prevention				
School-based programmes	<ul style="list-style-type: none"> Studies of school-based programmes have tended to be based on educational approaches. 	1++	20 (80) ^{vii}	Chester, Chorley, Congleton, Cumbria, Halton, Knowsley, Liverpool, Manchester, Salford, Sefton, Blackpool, Trafford, Warrington, Wigan, Bolton
	<ul style="list-style-type: none"> There is conflicting evidence about the effectiveness of programmes based on social influences approaches and limited evidence for the effects of other approaches, including developing generic social competence and multi-modal programmes. 	1++		
	<ul style="list-style-type: none"> There is limited evidence that school-based anti-smoking competitions can have a positive impact on daily smoking rates. 	1+		
	<ul style="list-style-type: none"> Emerging evidence suggests that interpersonal approaches delivered in a school setting, such as those examined in the ASSIST study may be 	1+		

^v All interventions have been included as all are viewed as having a direct or indirect impact upon children's exposure to SHS. Each questionnaire response has been treated as one intervention although these may comprise of a number of components (Total sample = 25).

^{vi} Comprehensive tobacco control programmes included those comprising of smoking cessation, smoking prevention and tobacco control components (including smoke free place policies). Pricing policies were not included due to the localized level of the data.

^{vii} Some areas (LA) have more than one type of intervention delivered in schools

	effective.			
Community-based programmes	<ul style="list-style-type: none"> There is limited support for the effectiveness of multicomponent community-based interventions for preventing the uptake of smoking 	1++		
	<ul style="list-style-type: none"> There is insufficient evidence to determine whether Smokebusters clubs are effective in terms of reducing smoking, although there is evidence that the programme may improve childhood knowledge and awareness of the hazards of smoking. 	2+	25 (100)	All (23)
	<ul style="list-style-type: none"> There is limited evidence for the effectiveness of prevention interventions delivered in primary care and dental settings. 	2+		
Family-based programmes	<ul style="list-style-type: none"> Family-based interventions have tended to be complex interventions, of which the parenting programme is only one component. 	1++	4 (16)	Wigan, Allerdale, Carlisle, Eden, Copeland, South Lakeland, Barrow-In-Furness, Bolton, Chester, Ellesmere Port & Neston
	<ul style="list-style-type: none"> A strong evidence base for the effectiveness of family-based interventions is lacking. 	1++		
Mass media interventions	<ul style="list-style-type: none"> Mass media campaigns can be effective in preventing the uptake of smoking in young people, particularly when combined with other intervention approaches. 	2+		
	<ul style="list-style-type: none"> Campaigns of longer duration and higher intensity appear to be associated with greater declines in smoking rates. 	2+	1 (4)	Sefton
	<ul style="list-style-type: none"> Developmental work with representative samples of the target audience should be carried out prior to intervention delivery and campaign messages should be guided by theoretical concepts about how behaviours are acquired and maintained. 	2+		
Advocacy	<ul style="list-style-type: none"> Comprehensive approaches to tobacco control focusing on policy advocacy may result in policy changes for tobacco control that have in turn may reduce smoking prevalence 	3	1 (4)	Liverpool ^{viii}
Smoking cessation	<ul style="list-style-type: none"> Cessation approaches which have demonstrated effectiveness are complex and designed to respond to the many issues that characterise young peoples' smoking; <ul style="list-style-type: none"> Programmes based on motivational enhancement, cognitive-behavioural therapy and the transtheoretical model of change have 	1+	2 (8)	Blackpool, Knowsley

^{viii} See Section 7 for information on advocacy initiatives in the North West identified in addition to the mapping

	<p>demonstrated some success.</p> <ul style="list-style-type: none"> Few studies have examined pharmacological approaches to cessation with young people, and of those studies that have, the results for the effectiveness of nicotine replacement therapy (NRT) (patch or gum), and bupropion (Zyban) as an adjunct to NRT, are inconclusive. An evaluation of eight youth cessation pilot programmes in Scotland provides little support to the case for developing dedicated youth cessation services. A study of adolescent preferences for smoking cessation services identified that current models of provision may not meet the needs of young smokers. 	1+		
Smoking cessation for pregnant women	<ul style="list-style-type: none"> Smoking cessation programmes for pregnant women have been shown to significantly reduce smoking rates. 	1++	9 (13)	Chester, Ellesmere Port & Neston, Knowsley, Salford, Trafford, Liverpool, Blackpool, St Helens, Pendle, Warrington, Manchester
	<ul style="list-style-type: none"> Self-help interventions are more effective than usual care, but there is no evidence that intervention materials of greater intensity increase quitting significantly over materials of lesser intensity. 	1++		
	<ul style="list-style-type: none"> There is limited evidence that that telephone support in combination with home visits or other face-to-face sessions may have a beneficial effect on smoking abstinence and relapse in pregnant and postpartum women. 	1+		
	<ul style="list-style-type: none"> There is currently no evidence to support the implementation of smoking cessation interventions for postpartum women. 	1+		
Reducing under aged sales of tobacco	<ul style="list-style-type: none"> The main intervention approaches that have been examined for reducing underage access to tobacco include: <ul style="list-style-type: none"> education about legal requirements, notification of the results of compliance checks, and warnings of enforcement by police or health officials. 	2+	23 (92)	All except Ribble Valley (22)
	<ul style="list-style-type: none"> Successful interventions have used a variety of strategies, including personal visits and mobilising community support, but sustaining compliance requires regular enforcement. 	2+		
	<ul style="list-style-type: none"> The success of access restrictions may be impeded by youth's ability to access tobacco products from social sources (e.g. friends, siblings, parents and private sellers). 	2+		
NW – North West; LA – Local Authority				

Key:

- 1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
- 1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
- 1-* Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
- 2++ High quality systematic reviews of, or individual high quality non-randomised intervention studies (controlled non-randomised trial, controlled before-and-after study, interrupted time series), comparative cohort and correlation studies with low risk of confounding, bias or chance
- 2+ Well conducted, non-randomised intervention studies (controlled non-randomised trial, controlled before-and-after study, interrupted time series), comparative cohort and correlation studies with low risk of confounding, bias or chance
- 2-* Non-randomised intervention studies (controlled non-randomised trial, controlled before-and-after study, interrupted time series), comparative cohort and correlation studies with high risk of confounding, bias or chance
- 3 Non-analytical studies (e.g. case reports, case series)
- 4 Expert opinion, formal consensus

8 Discussion and recommendations

The findings of the mapping showed that a range of approaches that both directly and indirectly aim to protect children and young people from exposure to tobacco are in place across the North West. These include services targeting adults, children, young people, pregnant women and programmes that aim to reduce underage sales and enforce smoke free legislation. However a lack of response by some LAs and PCTs means that there may be other services, intervention and activities that were not captured in the mapping.

8.1 Reducing exposure to SHS

Most SHS exposure occurs within the home and smoke free home schemes and/or training on SHS are being delivered or developed in a number of areas across the North West. The evidence review identified that a range of interventions have been used to try to reduce exposure, at both an individual and population level. Although there is no clear evidence for the most effective approaches which target individual behaviours, there is limited support for interventions based on intensive counselling for families and carers within a clinical setting (Priest et al., 2008), and home-based interventions (Gehrman and Hovell, 2003) .

Recommendation 1: Smoke free North West should ensure that smoke free home schemes and training on SHS are being implemented region-wide. Schemes should be developed at a local level and evaluated.

8.2 Smoking prevention

The mapping identified that schools were a popular setting for the delivery of smoking prevention activities, but it is unclear whether a consistent approach is being taken across the region. The evidence review identified that there is some evidence that school programmes incorporating social influences models (e.g. those based on Life Skills) can affect smoking behaviour in the short term, however there is limited evidence that these approaches are effective in the long term (Thomas and Perera, 2006b; Wiehe et al., 2005). New approaches to smoking prevention within the school setting, such as ASSIST (a peer-led approach targeting social networks within in schools), have shown promise (Campbell et al., 2008).

Recommendation 2: Smokefree North West should ensure that school-based programmes are based on the best available evidence (i.e. social influence approaches). In addition, Smokefree North West may wish to consider conducting a region wide evaluation of new approaches such as the peer-led intervention evaluated in the ASSIST trial.

Comprehensive community-wide interventions that incorporate a range of tobacco control activities have been shown to be more effective than school-based intervention alone (Biglan et al., 2000). The results of the mapping indicated that across the NW, services are being delivering across a variety of locations in addition to schools. However, currently a strong evidence base is lacking for the effectiveness of family-based interventions (Thomas et al., 2007).

Mass media campaigns have been shown to be effective in preventing the uptake of smoking in young people (Sowden, 1998), particularly when combined with other intervention approaches (Hopkins et al., 2001). Campaigns of longer duration and higher intensity appear to be more effective (Friend and Levy, 2002), and developmental work should be carried out with representative samples of the target audience prior to delivery (Sowden, 1998). The mapping identified that Sefton was the only area in the North West that was currently delivering a coordinated mass media campaign targeting young people.

Recommendation 3: Smokefree North West should implement NICE guidance (see Box 2) and develop regional and/or local mass media campaigns to prevent the uptake of smoking among young people. Regional and local campaigns should build on, and be integrated with, a national communications strategy to tackle tobacco use.

Box 2: NICE public health guidance 14 - Mass media

Recommendation 1: campaign development

Who is the target population?

- Children and young people under 18

Who should take action?

- Organisers and planners of national, regional and local mass-media campaigns.
- Local and regional commissioners and planners (including regional tobacco programme managers) with a remit to improve the health and wellbeing of children and young people under 18. This includes those working in the NHS, local authorities and tobacco control alliances.

What action should they take?

- Develop national, regional or local mass media campaigns to prevent the uptake of smoking among young people under 18. The campaigns should:
 - be informed by research that identifies and understands the target audiences
 - consider groups which epidemiological data indicate have higher than average or rising rates of smoking
 - be developed in partnership with: national, regional and local government and non-governmental organisations, the NHS, children and young people, media professionals (using their best practice), healthcare professionals, public relations agencies and local anti-tobacco activists.
- The campaign(s) should not be developed

in conjunction with the tobacco industry.

Recommendation 2: campaign messages

Who is the target population?

- Children and young people under 18

Who should take action?

- Organisers and planners of national, regional and local mass-media campaigns.
- Local and regional commissioners and planners (including regional tobacco programme managers) with a remit to improve the health and wellbeing of children and young people under 18. This includes those working in the NHS, local authorities and tobacco control alliances.

What action should they take?

- Convey messages based on strategic research and qualitative pre- and post-testing with the target audiences. These could include messages that:
- Elicit a strong, negative emotional reaction (for example, loss, disgust, fear) while providing sources of further information and support
 - portray tobacco as a deadly product, not just as a drug that is inappropriate for children and young people to use
 - use personal testimonials that children and young people can relate to
 - are presented by celebrities to whom children and young people can relate (taking care to avoid credibility and other problems)
 - empower children and young people

- to refuse offers of cigarettes
- include graphic images portraying smoking's detrimental effect on health as well as appearance (for example, its effect on the appearance of skin and teeth).

Recommendation 3: campaign strategies

Who is the target population?

- Children and young people under 18.

Who should take action?

- Organisers and planners of national, regional and local mass-media campaigns.
- Local and regional commissioners and planners (including regional tobacco programme managers) with a remit to improve the health and wellbeing of children and young people under 18. This includes those working in the NHS, local authorities and tobacco control alliances.

What action should they take?

- Use a range of strategies as part of any campaign to reduce the attractiveness of tobacco and contribute to changing society's attitude towards tobacco use, so that smoking is not considered the norm by any group. Strategies could include:
 - generating news by writing articles, commissioning news worthy research and issuing press releases
 - using posters, brochures and other materials to promote the campaign
 - using opportunities arising from new media.
- The campaign(s) should not be delivered in conjunction with (or supported by) the tobacco industry.
- National campaigns should exploit the full range of media used by children and young people, including television advertising.

8.3 Smoking cessation

The mapping identified that some cessation services in the North West are specifically targeting young people, such as the Stop Smoking Clinics which have been implemented in high schools across Blackpool. However, no independent evaluations of such services were identified. Research regarding smoking cessation interventions for adolescents is at an early stage (Grimshaw and Stanton, 2006; Mermelstein, 2003), and there is currently insufficient evidence to suggest which particular approaches are most effective. However, complex programmes, including those based on motivational enhancement, cognitive-behavioural therapy and 'stage of change' theory have demonstrated success (Grimshaw and Stanton, 2006; Sussman et al., 2006). Studies that have examined the effectiveness of NRT and pharmacological approaches to cessation with young people are inconclusive (Grimshaw and Stanton, 2006).

Recommendation 4: Given that the evidence base regarding smoking cessation interventions for young people is at an early stage, Smokefree North West should prioritise the evaluation of existing regional and local services.

8.4 Reducing underage access to tobacco

The mapping identified that a range of enforcement activities are conducted across the North West. The evidence review highlighted that interventions with multiple components are most effective for reducing youth access to tobacco, particularly when combined with ongoing enforcement (Richardson et al., 2007). Law enforcement or multi-component education programs are more effective than

informing retailers of minimum age restrictions (Richardson et al., 2007). The success of access restrictions may be limited by youth's ability to access tobacco products from social sources (Richardson et al., 2007).

Recommendation 5: Smokefree North West should implement NICE guidance (see Box 3) and take action to make it as difficult as possible for young people under 18 to get cigarettes and other tobacco products.

Box 3: NICE public health guidance 14 – Illegal sales

Recommendation 1

Who is the target population?

- Children and young people under 18

Who should take action?

- National government

What action should they take?

- Support better enforcement of existing legislation by:
 - working with the Local Better Regulation Office to make illegal tobacco sales a higher priority for local authorities, thereby increasing inspection and enforcement activities.
 - encouraging and providing all local authorities with support to:
 - ❖ enforce legislation to prevent under-age tobacco sales, in accordance with their statutory role and best practice
 - ❖ undertake regular audits of test purchasing to ensure consistent practice and enforcement
 - encouraging national organisations and local authorities to provide education and training programmes for trading standards officers
 - working with government agencies and national organisations to ensure retailers and others, such as publicans, are aware of legislation on under-age tobacco sales (including the fact that it covers vending machines)
 - ensuring magistrates are aware of the:
 - ❖ potential damage that smoking can do to children and young people and hence, the need to deter non-compliance among retailers
 - ❖ range of measures available to

deter retailers from making under-age tobacco sales, including the use of fines up to level four on the standard scale and the granting of either a 'restricted premises' or 'restricted sales order' (Criminal Justice and Immigration Act, due to come into force March 2009).

- Ensure enforcement efforts are sustained over a number of years.

Recommendation 5

Who is the target population?

- Retailers.

Who should take action?

- Local authorities and trading standards bodies.

What action should they take?

- Ensure retailers are aware of legislation prohibiting under-age tobacco sales by:
 - providing training and guidance on how to avoid illegal sales
 - encouraging them to:
 - ❖ request proof of age from anyone who appears younger than 18 who attempts to buy cigarettes and get it verified. (Examples of proof-of-age include a passport or driving licence or cards bearing the nationally-accredited 'PASS' hologram)
 - ❖ complete the 'Age restricted products refusal register' for each tobacco sale refused on the grounds of age
 - running campaigns to publicise the legislation. These could include details of possible fines that retailers can face, where tobacco is being sold illegally and successful local prosecutions, as well as health

information.

- Make it as difficult as possible for young people under 18 to get cigarettes and other tobacco products. In particular, exercise a statutory duty under the Children and Young Persons (protection from tobacco) Act 1991 to prevent under-age sales by:
 - prosecuting retailers who persistently break the law
 - taking enforcement action if tobacco vending machines are being used by children and young people under 18
 - undertaking test purchases each year, using local data to detect breaches in the law and auditing them regularly to ensure consistent practice across all local authorities.
- Ensure owners of vending machines and those who have them on their premises take all reasonable precautions to prevent under-age tobacco sales, in accordance with the law.
- Give practical advice on how to avoid illegal sales via vending machines (for example, they should be located in places where they can easily be controlled or

supervised). The National Association of Cigarette Machine Operators (NACMO) has issued guidance on the positioning of vending machines.

- Work with other agencies to identify areas where under-age tobacco sales are a particular problem.
- Work with the Local Better Regulation Office to improve inspection and enforcement activities related to illegal tobacco sales.
- Assess whether an advocacy campaign is needed to support enforcement. Any such campaign should be run in accordance with best practice and provide a clear, published statement on how to deal with under-age tobacco sales.
- Actively discourage use of enforcement and related campaigns developed by the tobacco industry.
- Ensure efforts to reduce illegal tobacco sales by retailers are sustained.

8.5 Conclusions

Overall the evidence review and mapping identified that a range of approaches, which both directly and indirectly aim to protect children and young people from exposure to tobacco, are in place across the North West. However, the evidence base for which approaches are most effective is lacking, particularly in relation to smoking cessation. There needs to be evaluation of the effectiveness of programmes at a local and regional level, with an emphasis on the processes involved in service delivery and the outcomes for young people. In addition, systems should be in place to learn from local experience.

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Appendix A. Mapping questionnaire



Reviewing the evidence relating to new tobacco control priorities that aim to protect children and young people from exposure to tobacco.

This mapping exercise intends to capture services, activities, programmes and interventions in the Northwest that aim to protect children and young people from exposure to tobacco. This includes a wide variety of services such as school based education, community based cessation services, test purchasing and interventions aimed at families in order to raise awareness of the dangers of second hand smoke.

Please complete the following questions providing as much detail as possible. If you have more than one service for young people and families please fill a sheet out for each service individually. The findings from this study will help develop future smoking prevention, tobacco control and health promotion activities and services in the North West. **Your help is much appreciated. By returning this questionnaire it is taken that you consent to participate in this study. Only include information you consent to being included in the final report.**

NAME OF SERVICE/INTERVENTION

GEOGRAPHICAL AREA (Please identify the region where the service/intervention is based and postcode/s):

Area:

Postcode/s:

At what level is that service delivered?

PCT []

Local authority []

Regional []

National (NGO) []

CONTACT DETAILS (only include information you consent to being included in the report):

NAME:

ADDRESS:

EMAIL:

TEL:

AIMS AND OBJECTIVES OF THE SERVICE/INTERVENTION

DOES YOUR SERVICE FALL UNDER THE FOLLOWING: (Please tick accordingly)

- Smoking cessation []
- Smoking prevention []
- Both smoking cessation and prevention []
- Tobacco control []

PLEASE PROVIDE A DESCRIPTION OF YOUR SERVICE/INTERVENTION:

PLEASE PROVIDE A DESCRIPTION OF ANY ADVOCACY ELEMENTS TO YOUR SERVICE PROVISION (if applicable)

WHERE IS THE SERVICE/ INTERVENTION DELIVERED? (Please tick all appropriate)

- Schools []
- G.P surgery/clinic / hospital [] Please specify:
- Community centres []
- Church hall []
- Through outreach (e.g. Street based or public event) []
- Through media formats (e.g. TV, internet) [] Please specify:
- Internet sites [] Please specify:
- Point of sale (e.g. newsagent/supermarket) []
- Other (Please specify):

WHO IS YOUR TARGET POPULATION?(Please tick all appropriate)

- Adults []
- Children (e.g. tobacco exposure) []
- Young people []
- Smokers []
- Non smokers []
- Pregnant women []
- Other [] Please specify:

WHAT NATIONAL AND LOCAL TARGETS DO YOU ACTIVELY MONITOR YOUR WORK TOWARDS?

NATIONAL:

LOCAL:

EVIDENCE OF EFFECTIVENESS (Please list any evidence you have on the effectiveness of this service/intervention such as outcomes from evaluation relating to the protection of children and young people from exposure to tobacco. If you have electronic copies of evaluation reports/papers which can be included in our mapping please send them to K.Woolfall@ljamu.ac.uk)

COSTS (Please list the overall annual cost of this service/intervention (e.g. total for the last full year) :

FUNDING (Please list all current sources of funding and amounts for each funding body):

STAFFING STRUCTURE(please detail the number of staff in employment (full and part time) and their job roles within your service/intervention. Please include seconded staff.

OTHER CONTACTS (Please give details for any other tobacco related services in your area who you think should be captured in this mapping exercise including contact name, service name, telephone and email address:

Many thanks for your participation. Please email or post this form to: Kerry Woolfall, Senior Researcher, Research Directorate, Centre for Public Health, Liverpool JMU, 5th Floor, Kingsway House, Hatton Garden, Liverpool, L3 2EZ. Tel: +44 151 231 8739. Fax: +44 151 231 4515. Email: K.Woolfall@ljamu.ac.uk

Appendix B: Mapping services, activities, programmes and interventions in the North West that aim to protect children and young people from exposure to tobacco.

<p>Stop Smoking Service: Blackpool Intermediate Health Mentor Scheme</p> <p>Geographical area: PCT and Local Authority Level: Blackpool</p> <p>Contact: Fay Watson</p> <p>Address: Stop Smoking Service, Blackpool Football Stadium, Seaside's Way, Blackpool, FY1 6JX</p> <p>Email: fay.watson@blackpoolpct.nhs.uk</p> <p>TEL: 01253 651692</p> <p>Aims and objectives: The overarching aim is to deliver a smoking cessation and tobacco prevention service in schools. This includes: Training all School Health Mentors in Blackpool to intermediate level; Gaining agreement from high schools in Blackpool to establish a Stop Smoking Service (run by the health mentors) in all Blackpool high schools and making the NRT Voucher Scheme available to the school health mentors and to young people aged 12-18</p> <p>Focus of service/intervention: Smoking cessation and prevention</p> <p>Brief description of service/intervention: School health mentors have established a range of Stop Smoking Clinics in high schools across Blackpool. Each of the mentors has access to the voucher scheme, enabling them to provide Nicotine Replacement Therapy products to young people who require them. They also are trained to provide behavioural change advice and are very creative in coming up with ways to get the message of tobacco across to the young people they work with. The health mentors have become keen advocates of the local stop smoking service and the service relies on them to engage young people into the quitting process as well as helping to prevent uptake of tobacco. The Blackpool Stop Smoking Service provides resources and training to the Health Mentors. For young people who want to be seen outside of school, we have a trained intermediate health worker in Connect, our in-town health drop-in centre for young people aged under 25.</p> <p>Advocacy elements:(Not applicable)</p> <p>Location of delivery: Schools and clinic</p> <p>Target population: Children (e.g. tobacco exposure) young people, pregnant women (smokers and non smokers).</p> <p>Targets that work is actively monitored towards:</p> <p>National: 4-Week Quit Target.</p> <p>Local: Analysis of recruitment of under 18's to Stop Smoking Service</p> <p>Evidence of effectiveness:66% increase in the number of people aged under 18 registering with the service (based on comparison between Quarter 1 2006/07 and Quarter 1 2007/08).</p> <p>Costs:(Full costs not provided)Less than £400 (for training health mentors).</p> <p>Funding: Funded out of core Stop Smoking Service budget – health mentor training</p> <p>Staffing: 6 Full- Time Health Mentors</p>
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<p>Stop Smoking Service: Underage sale purchasing in Blackpool</p> <p>Geographical area: PCT and Local Authority Level: Blackpool</p> <p>Contact: Fay Watson</p> <p>Address: Stop Smoking Service, Blackpool Football Stadium, Seaside's Way, Blackpool, FY1 6JX</p> <p>Email: fay.watson@blackpoolpct.nhs.uk</p> <p>TEL: 01253 651692</p> <p>Aims and objectives: To increase test purchasing for underage sale of tobacco products in Blackpool. The main objectives are: for trading standards to sustain and increase the number of test purchases they currently conduct; to analyse the results in accordance with national average of underage sales; to take action as a result of underage sale purchasing; to analyse the year on year failure rate of test purchasing</p> <p>Focus of service/intervention: Tobacco control</p> <p>Brief description of service/intervention: The Head of Tobacco Control in Blackpool PCT has provided additional funding to carry out routine test purchasing in Blackpool to the local trading standards department. Last year (2007-2008), the Blackpool Trading Standards department carried out 20 test-purchasing operations, which included testing at 205 separate retail premises. Given the level of positive sales made from these test purchases, Blackpool PCT has increased funding of this activity for the current year.</p>

Advocacy elements:(Not applicable)
Location of delivery: Point of sale
Target population: Children and young people
Targets that work is actively monitored towards:
National: National average of underage sales.
Local: Number of reports submitted for prosecution.
Evidence of effectiveness:In 2007/08, whilst 205 retail environments were test purchased in Blackpool, there were 73 positive sales and 52 reports submitted for prosecution. The failure rate still remains high at 28.08%, compared to 15% nationally and this is seen as a high tobacco control priority locally.
Costs: (not provided)
Funding:The Head of Tobacco Control in Blackpool PCT
Staffing: (not provided)

Salford and Trafford Stop Smoking Service

Geographical area: PCT Level: Salford and Trafford
Contact: Erica Kinniburgh
Address: Salford PCT, St James's House, Pendleton Way M6 5FW
Email: Erica.kinniburgh@salford.nhs.uk
TEL: 0161 212 4050
Aims and objectives: The service is for any smoker who lives or works in Salford or Trafford who wants to stop smoking
Focus of service/intervention: Smoking cessation and tobacco control
Brief description of service/intervention: The service is in all GP practices with trained Practice Nurses or Health Care Assistants. It operates an NRT voucher scheme in nearly all Community Pharmacies and has a small number of specialist advisers for primary care, secondary care, workplace and BME communities. In Salford we have a Smoke Free Homes Scheme.
Advocacy elements: There is a Young People's Development worker for Tobacco Control based in the Youth Service, funded with NRF monies who has been doing advocacy work with young people.
Location of delivery: Schools, G.P surgery/clinic, community centres, church halls, outreach (e.g. Street based or public event), media formats (e.g. local TV, DoH and local council websites carry information about the service).
Target population: Adults, children (e.g. tobacco exposure), young people, pregnant women and BME communities (smokers and non smokers).
Targets that work is actively monitored towards:
NATIONAL: Government targets are passed down to PCT's for 4 week quitters
LOCAL: Four week quitters targets for both Salford and Trafford
Evidence of effectiveness: (Not provided)
Costs: (Not provided)
Funding: (Not provided)
Staffing: (Not provided)

Cumbria County Council Trading Standards

Geographical area: Cumbria
Contact: John Greenbank
Address: Fairfield, Station Road, Cockermouth, Cumbria, CA7 8HH
Email: john.greenbank@cumbriacc.gov.uk
TEL: 01900 325980
Aims and objectives: Inspection of tobacco product retailers & distribution of advisory leaflets to trade premises as part of education/awareness campaigns. Monitor the display of warning notices and point of sale advertising in retail premises and on vending machines. Investigation of all consumer/trade complaints alleging the sale of tobacco to under age children. Carry out a minimum of 100 test purchases from retailers and vending machines. Carry out a minimum of 100 test purchases from retailers and vending machines.
Focus of service/intervention: Tobacco control

Brief description of service/intervention: Inspection of tobacco product retailers & distribution of advisory leaflets to trade premises as part of education/awareness campaigns. Monitor the display of warning notices and point of sale advertising in retail premises and on vending machines. Investigation of all consumer/trade complaints alleging the sale of tobacco to under age children. Carry out a minimum of 100 test purchases from retailers and vending machines. Carry out a minimum of 100 test purchases from retailers and vending machines.

Advocacy elements:(Not applicable)

Location of delivery: media formats Point of sale and through seminars aimed at sellers of age restricted products (tobacco).

Target population: children (e.g. tobacco exposure), young people and retailers engaged in the sale of tobacco.

Targets that work is actively monitored towards:

LOCAL: 1) Trading Standards Business plan. 2) Local Area Agreements.

Evidence of effectiveness: (Not provided)

Costs: (Not provided)

Funding: No specific funding.

Staffing:Three members of staff spend less than 10% of their working time on under age sales of tobacco.

Congleton Borough Council Environmental Health

Geographical area: Congleton

Contact: Kathy Cornford

Address: Westfields, Middlewich Road, Sandbach Cheshire, CW11 1HZ

Email: Kathy.cornford@congleton.gov.uk

TEL: 01270 529681

Aims and objectives: Reduce the incidence of smoking and tobacco control

Focus of service/intervention: Smoking prevention and tobacco control

Brief description of service/intervention: Congleton Borough Council Environmental Health Officers are responsible for the enforcement of Health Act 2006 with regard to tobacco control in premises and vehicles. It is also involved in talks in schools to pupils regarding the health effects of smoking as part of its work to reduce the incidence of smoking.

Advocacy elements: (Not applicable)

Location of delivery:Schools and all premises to which the Health Act 2006 applies.

Target population: Adults, children (e.g. tobacco exposure), young people (smokers and non smokers).

Targets that work is actively monitored towards:

NATIONAL: Legislation; CIEH;

LOCAL: Tobacco Alliance East Cheshire

Evidence of effectiveness:

Costs: (Not provided)

Funding: (Not provided)

Staffing: One Environmental Health officer

St Helens Environmental Health; smoke free legislation enforcement

Geographical area: St Helens

Contact: Helen Williams

Address: St Helens MBC Environmental Health, Wesley House, Corporation Street, WA10 1H

Email: helenjwilliams@sthelens.gov.uk

TEL: 01744 456376

Aims and objectives: To enforce and educate regarding The Health Act 2006 and associated regulations.

Focus of service/intervention: Smoking prevention and tobacco control

Brief description of service/intervention: Routine inspections of commercial premises in relation checking compliance on smoke free legislation. Investigation of complaints of non compliance

Advocacy elements: (Not applicable)

Location of delivery: workplaces

Target population: All populations

Targets that work is actively monitored towards:

LOCAL: Internal performance indicators on appropriate response times to investigations

Evidence of effectiveness: No specific evidence in relation to children and young people. Reduction of environmental tobacco smoke has protected children within public places and enclosed spaces. Legislation and enforcement of the smokefree legislation has been successful locally and nationally in terms of compliance. Over 98% compliance

Costs: Department of Health Funding: over 18 months was £110,000. Funding now ceased.

Funding: None currently. Work undertaken by environmental health staff

Staffing: Not applicable

Knowsley Tobacco Control Strategy

Geographical area: Knowsley

Contact: Clair Harris

Address: Nutgrove Villa, Westmoreland Road, Huyton Merseyside. L36 6GA

Email: clair.harris@knowsley.gov.uk

TEL: 0151 443 4846

Aims and objectives: To provide smoke free awareness and targeted interventions on smoke free in community settings with a focus on children, individuals and families.

Test purchasing initiatives, training, retailer schemes and intel to restrict the supply and distribution of tobacco to children

To provide education interventions to children in primary school regarding smoking

To provide a service to young people and teenagers offering information, education and stop smoking support where required.

Focus of service/intervention: Smoking cessation, prevention and tobacco control.

Advocacy elements: This is under development in Knowsley via the Links scheme.

Brief description of service/intervention: Community development worker develops projects and training in relation to Smoke Free.

Trading Standards (team) based support around age restricted products with a key focus on tobacco. Retailer Scheme, training and information awareness. Work with HRMC on illicit tobacco supply.

Smoking prevention activity through healthy schools and classroom based education sessions for primary school age children and year 8.

Smoking cessation service offers sessional group and one to one support to young people in schools.

Location of delivery: Schools, workplace and community based settings

Target population: Children and young people, retailers, smokers and non smokers

Targets that work is actively monitored towards:

NATIONAL:

PSA target to reduce children smoking to 9% by 2008

Infant inequalities target reduction on smoking in pregnancy

LOCAL:

Smoking in pregnancy – to reduce by 2% points year on year (Vital Sign Target)

Smoking in young people – Year 10 girls (2% points each year) boys (1% point each year).

Evidence of effectiveness: No formal outcome evaluation but the impact of the Knowsley Tobacco Strategy and Services. There has been a reduction of the rates of smoking among school age children and reducing second hand smoke exposure in homes in Knowsley: Smoking amongst year 10 girls from 17% in 2007 to 14% in 2008; smoking amongst year 10 boys from 9% in 2007 to 8% in 2008; children's second hand smoke exposure in the home reduced from 68% in 2007 58% in 2009.

Costs: Young people's smoking service £145, 000 recurrent. Trading Standards Service - £40,000 recurrent. Smoke Free Community Development £35,000 recurrent

Funding: All current funding is PCT.

Staffing: 8 Smoking Cessation Advisers in School Health, 1 Community Development Worker 1, Lead Trading Standards Officer + enforcement team.

Warrington Stop Smoking Service

Geographical area: Warrington

Contact: Bruce Gillibrand

Address: 930-932 Birchwood Boulevard, Birchwood, Warrington, Cheshire. WA37QN

Email: bruce.gillibrand@warrington-pct.nhs.uk

TEL: 01925 843713

Aims and objectives: To stop and reduce the number of people living/working in Warrington. To reduce the prevalence of young people smoking in Warrington.

Focus of service/intervention: smoking cessation , prevention and tobacco control

Brief description of service/intervention: One to one sessions, drop in sessions, group sessions, weekend/evening clinics, brief intervention training, tobacco control, smoking in pregnancy, children and young people, drop in sessions for young people at the Youth Advice Shop, Smoke Free Schools Award, tobacco awareness sessions in schools.

Advocacy elements: (Not applicable)

Location of delivery: Schools, G.P surgery/clinic / hospital, Community centres, outreach, radio, Bus stops/Bill boards

Target population: Adults, children, young people, smokers and pregnant women.

Targets that work is actively monitored towards:

NATIONAL: DOH

LOCAL: LPSA /LAA /SLA

Evidence of effectiveness:40 Schools achieved silver smoke free schools award. One School achieved gold smoke free schools award. 900 pupils successfully engaged in the No Smoking Day roadshow, March 2008.

Costs: Smoking cessation £288.972 Tobacco control £22.643. Total = £311.643

Funding: (Not provided)

Staffing: 1: Lifestyles coordinator FT; 1: Lifestyles specialist FT; 8: Stop smoking advisors 3 x FT / 5 x PT; 1: Tobacco Control lead FT; 2: Smoking in Pregnancy midwives PT

Pendle Local Authority tobacco control (Environmental Health Services)

Geographical area: Pendle

Postcodes: BB8, BB9, BB18, BB10

Contact: (no details provided)

Aims and objectives: (not provided)

Focus of service/intervention: smoking prevention and tobacco control

Brief description of service/intervention: Smokefree enforcement is the main activity. However, the aim is to balance our enforcement activity with promotional interventions. To do this the Local Authority Tobacco control have developed a close working relationship with the local NHS Stop Smoking Service with whom the LA seek to work innovatively. Pendle Local Authority have provided funding to the Service to increase capacity to provide a specialist nurse advisor to deal with the increasing demand for Champix and to cut the waiting times for one to one appointments.

The Local Authority tobacco control have also worked collaboratively on production of bespoke forum theatre on smoking issues – Clearing the Air which toured the area earlier this year and has now been made into a DVD. This has been piloted by NHS East Lancashire for use in staff training and recruitment. We hope to work collaboratively to produce learning materials to support the DVD and to offer the resource to a variety of different agencies. The DVD targets several groups including young people and pregnant women.

Local Authority tobacco control are members of the East Lancashire Tobacco Control Group and contribute to the joint action plan. They have also developed an East Lancashire Local Authorities action plan to help us integrate promotional activity into our routine work more effectively. For example we will focus on illicit tobacco within our workplace health work, and we our working towards a voluntary smokefree playgrounds charter.

Local Authority tobacco control have recently been successful in a bid for additional funding to help tackle the ongoing problems of smoking in works vehicles.

Advocacy elements: The proposed work with workplaces will involve some advocacy.

Location of delivery: Community centres and through outreach

Target population: Adults, children, young people, smokers, non smokers and pregnant women.

Targets that work is actively monitored towards:

NATIONAL: NI 123, PSA 18

LOCAL: LAA H4 – Number of people who have set a quit date and who are still not smoking at 4 weeks recorded to DoH protocol and submitted by PCT on a quarterly basis

LAA H5 – Adult smoking rates as measured by 52 week quitters

LAA H9 - Percentage of pregnant women who are not smoking at delivery

Evidence of effectiveness: Contribute to the progress towards the above targets but the effectiveness of individual input is not measured.

Costs: This work is carried out as a proportion (15%) of the total work of a part time (25 hours /week) Environmental Health Officer

Funding: This work is provided from core funding

Staffing: 1 part time EHO covering public health promotion generally with special responsibility for smoke free issues

Bolton Healthy Schools Programme

Geographical area: Bolton

Contact: Marie Bisset

ADDRESS: Public Health, St Peters House, Silverwell St, Bolton, BL1 1PP.

EMAIL: marie.bisset@bolton.nhs.uk

TEL: 01204 462163

Aims and objectives: To support schools with prevention education at all key stages, by teacher training, provision and development of resources, work directly with young people, parents and other school stakeholders. Also provision and support of cessation training

Focus of service/intervention: Both smoking cessation and prevention

Brief description of service/intervention: Training for teachers, resource provision, one to one support for schools.

Advocacy elements: (Not applicable)

Location of delivery: schools

Target population: adults, children and young people.

Targets that work is actively monitored towards:

NATIONAL: National Healthy Schools Programme

Evidence of effectiveness: None to date. The programme has only just employed someone with this remit.

Costs: Part of Healthy Schools funding approx. £5000

Funding: Healthy Schools Core Funding approx £120000

Staffing: HS team: One co-ordinator (F/T), two development officers (F/T term time), two development officers (P/T term time). All trained to Level2.

PSHE TEAM/CYPS Life Education Programme

Geographical area: Wigan

Contact: Shaun Moss

ADDRESS: 107 Standishgate

EMAIL: mossshaun@wigan.gov.uk

TEL: 01942-777720

Aims and objectives: The Life Education programme aims to: encourage positive attitudes to health, both physical and mental; develop the skills necessary to put healthy choices into practice and manage the challenges of peer pressure and decision making; understand the risks associated with, and the impact of drugs (including tobacco, alcohol, medicines illegal and legal drugs); the rules and the laws relating to drugs; and the impact that drugs have on individuals, the family and the wider community.

Focus of service/intervention: Local authority and regional

Brief description of service/intervention: The Life Education programme is delivered in partnership with all local primary schools via a specially designed mobile classroom which is equipped to provide a stimulating and exciting learning environment. The Life Educators who deliver the programme use a range of techniques and strategies to enable children to develop confidence and the thinking skills that are needed to make informed health choices. The teaching methods used (as determined by the Life Educators based on age/ability of the

group) include: circle time; accelerated learning; theatre in education, audio visual materials; quizzes and games; role play and group work.

The work that is undertaken by the Life Educators with primary school children is determined by the age and baseline information gathered about the group. The programme supports schools in following and delivering recommended best practice in health and drug education detailed in the DfES publications *Drugs: Guidance for Schools (2004)*; *PSHE in Practice: Resource pack for Teachers in Primary Schools (2004)* and as defined in the PSHE & Citizenship section of the *National Curriculum (DfEE, 2000)*. The holistic approach to health and drug education adopted enables the programme to support the delivery of key objectives of the National Healthy School Standard (NHSS).

Life Education programme also work with parents and carers of primary school children. This involves undertaking workshops, orientation and awareness raising sessions with participants and is also delivered via the mobile classroom. The focus for working with parents and carers is to support the understanding of health education, the importance of good practice and the impact that actions can have on children, be this exposure from within the family setting or the wider community.

In addition the Life Education programme involves bringing children and parents together in order to consolidate learning and to mutually understand the impact of all drugs and the importance of a healthy living regime. The process is known as the "Assembly Programme" and the overall outcome is to provide information regarding promoting health choices, positive behaviour and supporting learning. The overarching purpose of this project is based on the understanding that drug education is a major component in drug prevention strategies. The Life Education programme aims to minimise the number of young people engaging in drug use, thus reducing the effects of long-term harm. This project enables children and parents/carers to develop their knowledge, skills, attitudes and understanding about drugs, appreciate the benefits of healthy living and relate this to their own, and other people's actions

Advocacy elements: (Not applicable)

Location of delivery: schools

Target population: adults, children and young people

Targets that work is actively monitored towards:

NATIONAL: SPA

LOCAL: CYPP, SPA

Evidence of effectiveness: No specific evidence of effectiveness although the programme is based upon the evidence base relating to drug education programmes which indicates that such programmes are effective if they adopt the following elements: Address knowledge, skills and attitudes, provide developmentally appropriate and culturally sensitive information; Challenge misconceptions that young people hold about the norms of their peers' behaviour and their friend' reaction to drug use. This 'normative education' is important because young people often overestimate how many of their own age group drink, smoke or use illegal drugs; Use interactive teaching techniques such as discussion, small group activities and roll play; Involve parents/carers as part of a wider community approach: parents/carers should have access to information and support in talking with their children about drugs.

Costs: 73,000

Funding:Wigan Rotary Club fund the project.

Staffing: 1 Part time Life Education Manager. 1 Part time Life Educator

Roy Castle Fag Ends

Geographical area: Liverpool

Contact: Jane Vautrinot

ADDRESS: Roy Castle Foundation, Enterprise Way, Wavertree Technology Park L13 1FB

EMAIL: Jane.vautrinot@roycastle.org

Aims and objectives: To prevent lung cancer and help and support people to stop smoking and remain smokefree.

Focus of service/intervention: Smoking prevention, cessation and tobacco control.

Brief description of service/intervention: Fag Ends have 58 drop in stop smoking support groups running each week and five one to one support services. Fag Ends give out nicotine replacement products on a voucher scheme and support/advice on Champix/Zyban. CO levels are monitored each time a client is seen. Fag Ends have specialist advisors for Young People, BME, Mental Health, Prisons, Homeless, Sure Start, 2 hospital based advisors,

midwife advisor and Workplace. In addition they also have two advisors who work in prevention with young people (ATYC and KATS). Advisors will also do home visits for house bound patients.

Advocacy elements: (not applicable)

Location of delivery: Schools, hospital clinics, community centres, outreach, Roy Castle Web site and point of sale (health promotion events).

Target population: adults, children and young people, pregnant women (smokers and non smokers)

Targets that work is actively monitored towards:

NATIONAL: Department of Health targets which are set each year

LOCAL: PCT – reduce prevalence of smokers in Liverpool

Evidence of effectiveness: (none provided)

Costs:(none provided)

Funding: Liverpool PCT (details not provided)

Staffing: 16 advisors, 2 admin

Roy Castle Fag Ends

Geographical area: Knowsley

Contact: Lynne Buoey

ADDRESS: 42 Cedar Road, Whiston, L35 2XA

EMAIL:lynne.buoey@roycastle.org

Aims and objectives: To prevent lung cancer and help and support people to stop smoking and remain smokefree.

Focus of service/intervention: Smoking cessation

Brief description of service/intervention:Roy Castle Fag Ends is a community based stop smoking service and provides support in a number of different ways and at a variety of settings. Details of the support provided can be seen in the Liverpool Fag Ends service description (above).

Advocacy elements: (not applicable)

Location of delivery: Schools, hospital clinics, community centres, church halls, outreach, Roy Castle and Fag Ends web site

Target population: adults, pregnant women, smokers

Targets that work is actively monitored towards:

NATIONAL: Department of Health targets which are set each year

LOCAL: PCT – reduce prevalence of smokers in Knowsley

Evidence of effectiveness: (none provided)

Costs:(none provided)

Funding:(details not provided)

Staffing: Managers (x2), team leader/ pregnancy specialist, admin manager, admin assistant, Stop Smoking advisors (x 8).

Tobacco control: Warrington

Geographical area: Warrington, Cheshire

Postcodes:WA1 1JN

Contact: Pete Astley

Aims and objectives: To help in the reduction of smoking prevalence in Warrington

Focus of service/intervention: Smoking prevention and tobacco control

Brief description of service/intervention:Development of Warrington wide Tobacco Control Action Plan. Increase awareness and access to the local stop smoking service. To develop and put in place training programmes including reducing children's exposure to second hand smoke. To provide support, advice and guidance on the law relating to tobacco. To work with enforcing agencies (e.g. trading standards, environmental health, police)

Advocacy elements: (not applicable)

Location of delivery:Schools, community centres, church hall, outreach, press releases, publicity events, council website.

Target population:adults, children and young people, pregnant women (smokers and non smokers)

Targets that work is actively monitored towards:

LOCAL: Stop smoking service activity including pregnancy. Smokefree legislation, compliance levels and availability of illicit tobacco.

Evidence of effectiveness:(no specific data provided)Underage sales test purchase programmes. Issue of proof of age cards, survey of year 10 purchasing and consumption behaviour. Smokefree children's service currently under development.

Costs:(none provided)

Funding:(none provided)

Staffing: 1 Tobacco Control Project Officer (30hrs per week) Seconded from the PCT and based in Trading Standards at the Local Authority.

Western Cheshire Primary Care Trust

Geographical area: Western Cheshire includes Chester and surround areas including Farndon, Malpas, Audlem, Bunbury, Tarporley, Frodsham, Elton and Ellesmere Port and surrounding areas including Neston, Parkgate, Burton, Willaston, Westminster and Stanlow.

Contact: Alison Paul, Tobacco Control Manager

ADDRESS: Western Cheshire PCT, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL

EMAIL: Alison.Paul@wcheshirepct.nhs.uk

TEL: 01244 650430

Aims and objectives: The Tobacco Control Alliance has been relaunched this autumn and children and young people are one of the key areas of focus.The new structure includes a strategic group and a maternity, children and young people action group. The aim of the strategic group is to ensure commitment and influence across partners and to direct the strategic for Western Cheshire. The action group will focus on practical actions to further to maternity, children and young people tobacco control agenda.Most groups had there first meeting last month where direction, membership and objectives were discussed.

Focus of service/intervention: Smoking cessation, prevention and tobacco control

Brief description of service/intervention: Currently the subject of smoking is raised at schools through PSHE classes and through contact with School Health Advisors. The Action Group wants to develop this programme and the group is identifying action we can deliver upon this year. This is focusing upon: current activity in schools and colleges; evaluating resources in terms of feedback from users, to see what is most effective and in what circumstance; creating three new young people advocacy groups through the Anti-Tobacco Youth Campaign (ATYC); developing the proposal for a smokefree homes project; coordinating messages from conception to age 19; review and if necessary amend the system for children and young people to access stop smoking services; Protect children through supporting women and other family members to stop smoking before delivery and to maintain a smokefree lifestyle after delivery.

Advocacy elements: The three new proposed Anti Tobacco Youth Campaign groups will encourage the children you be involved in advocacy.

Location of delivery: schools

Target population: children, young people and pregnant women

Targets that work is actively monitored towards:

NATIONAL: Working to national NICE standards and guidelines. National Healthy Schools standard.

LOCAL: Targets are being developed.

Evidence of effectiveness: (none provided)

Costs: (none provided)

Funding: Anti Tobacco Youth Campaign is currently funded via Big Lottery funding. Existing resources (e.g. items from GASP) have been bought though Health Promotion funding.

Staffing: Current projects are within existing job roles such as: Tobacco Control Manager, Health Promotion Lead for Children and Young People and Smoking Cessation Midwife. Plus our colleagues and partners

Trafford School Nursing Service

Geographical area: Trafford

Contact: Joanne Oakes

ADDRESS: Seymour Grove Health Centre, 70 Seymour Grove, Old Trafford, M16 0LW

EMAIL: joanne.oakes@trafford.nhs

TEL:0161 872 5672

Aims and objectives: Trafford school nurses aim to promote the health and well being of the school aged population within Trafford by delivering a service within schools, homes and other community settings. As part of this activities relating to smoking are carried out as below.

Focus of service/intervention: both smoking cessation and prevention

Brief description of service/intervention: Class based lessons to primary and secondary aged pupils aimed at educating children with regard to the risks of smoking (health, cost, environment etc). Anti Smoking road shows delivered to whole secondary school years. One to one advice to young people, including voucher scheme for NRT. One member of staff is employed part time term time only and part of that role is to work with schools in developing policies relating to drug education and to improving the standards of class room delivery in relation to this subject (funded via the Children and Young People's Service).

Advocacy elements: (not applicable)

Location of delivery: Schools, G.P surgery/clinic / hospital, Community centres and outreach

Target population: Children and young people

Targets that work is actively monitored towards:

NATIONAL: Not monitored

LOCAL: Nicotine replacement therapy activity is monitored via the Salford and Trafford Smoking Cessation Service.

Evidence of effectiveness: (none provided)

Costs:(none provided)

Funding:(none provided)

Staffing: The team consists of qualified nurses and support workers who all use part of there working hours to carry out smoking related activities.

Manchester Stop Smoking Service

Geographical area: Manchester

Contact: Emma Hawley

ADDRESS: Manchester Stop Smoking Service, Victoria Mill, Lower Vickers Street, Miles Platting, Manchester, M40 7LJ

EMAIL: emma.hawley@manchester.nhs.uk

TEL:0161 205 5996

Aims and objectives: The aims and objectives of MSSS are to: reduce adult smoking prevalence; reduce smoking related health inequalities; reducing smoking prevalence in young people ; reduce smoking prevalence in pregnancy; reduce exposure to second hand smoke across the city; increase public support for smokefree workplaces and public places

Focus of service/intervention: smoking cessation and prevention

Brief description of service/intervention: Manchester Stop Smoking Service provides support to those people living and working in Manchester who want to stop smoking; whilst also delivering work to prevent people from starting to smoke and work to protect children and adults from exposure to second hand smoke. The service provides a range of confidential services including one to one support, access to NRT, deliver Manchester Smokefree Homes Scheme and provide training for professionals on smoking cessation. The service has a number of specialist staff working to develop support in targeted areas including: pregnant women; children & young people ; BME communities; specific areas of deprivation. The service has a programme in place with the aim of preventing / reducing smoking in pregnancy through engaging with midwives and staff at Sure Start Children's Centres.

MSSS runs the Manchester Smokefree Homes Scheme which works to raise awareness of the dangers of exposure to second hand tobacco smoke and encourages Manchester residents to commit to having a Smokefree home. MSSS also has a role within the Healthy Schools team to support the delivery of tobacco education within schools and to oversee policy development in relation to the school setting. MSSS fund a programme which is delivered by Manchester City Football Club (communities section) and is offered to all primary school year 5 groups in Manchester.

The service is in the process of expanding its provision to meet the needs of young people. At present we are running a number of drop-in's at Manchester college's, sexual health clinics and other settings. MSSS are delivering info stalls at a range of young people's venues across the city. Work has been completed to raise awareness about the service to young people's agencies and in the new year (2009) The service will be rolling out a programme of training for young people's practitioners, with the aim of encouraging young people's services to offer smoking cessation interventions to their clients.

Advocacy elements: (not applicable)

Location of delivery: Schools, hospital clinics (Manchester Royal Infirmary, Manchester General, Wythenshawe, Withington Community Hospital), community centres, church halls, outreach, and internet (<http://www.stopsmokingmanchester.co.uk>)

Target population: adults, children and young people, pregnant women (smokers and non smokers)

Targets that work is actively monitored towards:

NATIONAL: 1% fall per year in smoking prevalence in pregnancy.

Number of 4-week smoking quitters who attended NHS Stop Smoking Services. Population aged 16 and over. Smoking quitters per 100,000 population aged 16 and over.

LOCAL: 1.5% fall per year in smoking prevalence in pregnancy.

Evidence of effectiveness: (none provided)

Costs:(none provided)

Funding:(none provided)

Staffing:

Public Health Development Senior Manager Stop Smoking Service. Senior Public Health Development Advisor – Pregnancy & Smokefree Homes (PT). Senior Public Health Development Advisor – Pregnancy (PT). Senior Public Health Development Advisor – Community & Tobacco Control (PT). Senior Public Health Development Advisor – Young People, & Tobacco Control (FT). Primary Care Project Development Worker (FT). Communications Officer (FT). Administration Support Stop Smoking Service. Finance & Administration Support Stop Smoking Service (2 x FT, 1 x PT) 9 x Specialist Smoking Cessation Advisor (PT) Bank: comprising of number of trained workers who provide additional advisor work for the service

Sefton Support NHS Stop Smoking Service

Geographical area: Sefton

Contact: Carmel Fraser

ADDRESS: Litherland Town Hall Health Centre. Hatton Hill Road, Litherland, L22 9JN

EMAIL: carmel.fraser@sefton.nhs.uk

TEL: 0151 475 4207

Aims and objectives: To help reduce smoking prevalence within Sefton and help people achieve their goal. To provide a service to give people an informed choice of when and how they want to stop smoking with a choice of treatments and support.

Focus of service/intervention: smoking cessation and prevention

Brief description of service/intervention: Provision of support, advice and treatments to help people stop smoking on a one to one and group support basis. Sessions held within local community settings in the above postcode areas access available through self-referral or via health professional through drop in or self made appointments. Service also provides training in brief interventions; smoking cessation two day training and second hand smoke. Promotes service through support worker events - shopping centres, workplaces, schools, links with health improvement, healthy schools, school nurses and children's centres.

Advocacy elements: Volunteer support for service at events through expert patient programme and co ordinated through PALS.

Location of delivery: Schools, hospital clinics, community centres, outreach.

Target population: adults, children and young people, pregnant women (smokers and non smokers)

Targets that work is actively monitored towards:

NATIONAL: 4 week successful quits

LOCAL: 4 week successful quits; men accessing service and women under 34 accessing service and 4 week quits.

Evidence of effectiveness: See appendix C

Costs:(none provided)

Funding:(none provided)

Staffing: Service manager 1wte; lead specialists- 1 wte. 4 x (P/T) Smoking cessation nurses - 1 wte. 8 x (p/T)– 3.5 wte Smoking cessation advisors - 2 wte. Smoking cessation support workers – 2 wte 1x Secretary - part time. Admin support - 1 wte

DMYST (Direct Movement by the Youth SmokeFree Team)

Geographical area: Liverpool

Contact: Danielle Maloney

ADDRESS: DMYST, Liverpool Health Promotion Service, 10 Maryland Street, Liverpool, L1 9DE

EMAIL: danielle.maloney@liverpoolpct.nhs.uk

TEL: 0151 707 1555

Aims and objectives: DMYST is a smokefree movement run by and for young people in Liverpool. DMYST provides young people with an opportunity to air their views and concerns on tobacco and to take action to de-normalise and de-glamorise smoking by:raising the awareness of the dangers of tobacco and exposure to second-hand smoke amongst other young people; campaigning for and promoting smokefree environments for all; campaigning to get rid of smoking and the placement of tobacco products in the media that is predominantly targeted a young people, our campaign is pro smokefree, anti-tobacco, anti-industry and not anti-smoker

Focus of service/intervention: smoking prevention and tobacco control

Brief description of service/intervention: DMYST was launched in 2003 and since then have worked on many campaigns and issues some of which are below: In 2006, D-MYST launched their SmokeFree Stadia campaign with the aim of making Everton and Liverpool FC's stadiums 100% smokefree. The smokefree legislation proposed at the time did not include sports stadiums as they were classed as not enclosed spaces. However D-MYST and many other young people disagreed with this stating that when they went to a match if someone around them smoked it not only was bad for their health but ruined their enjoyment of the game. DMYST dedicated their summer holidays to the smokefree stadia campaign by attending events across the city and asking people to signing up and support smokefree stadiums. More than 8000 people signed the petition in support which D-MYST presented at Anfield stadium.

As a result of the campaign not only were D-MYST mentioned in the DoH consultation response but when the smokefree legislation came into place on the 1st of July 2007 all stadiums were declared smokefree.

The SmokeFree 'Scary Movies' campaign which aims to remove smoking from youth rated films is a result of D-MYST'S Toxic Movies campaign which was launched in 2007. Toxic Movies was launched by D-MYST as they felt that they were being targeted by the tobacco industry through their favourite films. This campaign raised the issue that smoking in films is the main reason young people start to smoke and action began. The campaign received huge support across the city with people signing letters addressed to the UK film regulators BBFC (British Board of Film Classification) asking them to give all future films containing smoking an '18' rating.

With no response from the BBFC regarding the letters; D-MYST asked for a meeting to discuss smoking in movies and how they are regulated, but were refused. To highlight the issue at a higher level and try and gain more support D-MYST held an International SmokeFree Movies conference in Liverpool. Following on from this the SmokeFree 'Scary Movies' campaign was launched in partnership with SmokeFree Liverpool. SmokeFree Movies is now asking the BBFC to recognise that smoking in films is an important issue, and then to use its existing powers to prevent smoking images being shown in newly classified films which can be seen by under-18s. You can help get smoking out of youth rated films by sending a letter directly to the BBFC. DMYST have recently teamed up with MD productions and SmokeFree Liverpool to hold a 'scary' street activity event on 30th October 2008 to raise awareness with the public of smoking in movies.

Advocacy elements: DMYST is the Youth Movement group of SmokeFree Liverpool whom supports our campaigning and sustains us financial through funding provided by Working Neighbourhood Fund and Liverpool Primary Care Trust.

Location of delivery: Schools, outreach, through media formats such as press releases, website and blogs.

Target population: young people and the tobacco and film industry

Targets that work is actively monitored towards:

NATIONAL: (not applicable)

LOCAL: WNF targets

Evidence of effectiveness: Research on Smoking Prevalence amongst Young people: Hoshin report (contact Danielle Maloney for further details)

Costs: (none provided)

Funding: Working Neighbourhood Fund

Staffing: One Programme Manager

Ribble Valley Borough Council- Environmental Health and Licensing Enforcement

Geographical area: North East Lancashire

Contact: James Russell, Environmental Health Manager

ADDRESS: Ribble Valley BC, Council Offices, Church Walk, CLITHEROE

EMAIL: james.russell@ribblevalley.gov.uk

TEL: 01200 414466

Aims and objectives: Enforcers for smoke free workplace, Health & Safety at Work, support activities of other agencies in reducing use of tobacco – health promotion and licensing enforcement.

Focus of service/intervention: Smoking prevention and tobacco control

Brief description of service/intervention: Smokefree workplace and Licensed Premise enforcement; health and safety enforcement and health promotion advice - referral to agency services

Advocacy elements: (not applicable)

Location of delivery: Direct to public – home visits, Licensing Inspection, commercial premise inspection

Target population: adults

Targets that work is actively monitored towards:

NATIONAL:

LOCAL: Number of smoke free premise inspections – 10% per year (@ 250 pa)

Evidence of effectiveness: Compliance with smoke free legislation (no specific evidence provided)

Costs: (none provided)

Funding: (none provided)

Staffing: (no specific details provided)

Healthy Schools (Chorley, Preston, South Ribble and West Lancashire)

Geographical area: Chorley, Preston, South Ribble and West Lancashire

Contact: (none provided)

Aims and objectives: In line with National healthy School Standards

Focus of service/intervention: smoking prevention

Brief description of service/intervention: Tobacco Control resources to all schools

Advocacy elements: (not applicable)

Location of delivery: schools

Target population: children and young people, pregnant women (smokers and non smokers)

Targets that work is actively monitored towards: National Health Schools Standards

NATIONAL:

LOCAL:

Evidence of effectiveness:

Costs: Many posts within the PCT have a remit around CYP and families with Health Schools (HS) forming part of this role which will delivery PCT priorities around tobacco control.

1 Public Health Consultant. 1 Band 7. 1.6 WTE band 6 Total approximately £132,000.

Many other members of the Public Health team will input indirectly to HS, Integrated School Health Teams (school nurses) and also the stop smoking team (provider). Full costs not available however posts include:

1 Head of school effectiveness (and DAT lead); 1 Co-ordinator; 1 Assistant co-ordinator; 1 Teacher Advisor (TA) – drug education; 1 TA – PSHE; 1 TA – Risk taking behaviour; 2 part-

time teacher consultant – one secondary one primary; 1 SEN teacher consultant; Dedicated administration time

Also costings for the following resources as follows (breakdown available at this time):

Health Schools Tobacco control Toolkit, HS PSHE resources; HS website www.lhsp.org.uk; HS accreditation – Quality mark in drug education (including alcohol & tobacco); National Healthy School Status (NHSS) self evaluating audit tool with tobacco covered within PSHE; PCT resources for school nurse.

Funding: City Council and PCT

Staffing: (as detailed above)

Cumbria Healthy Schools

Geographical area: Cumbria PCT

Contact: Anna Dutson

ADDRESS: 9-24 Friargate Penrith Cumbria

EMAIL: anna.dutson@cumbriacc.gov.uk

TEL: 01768 242077

Aims and objectives: To increase awareness amongst young people about the risks to health associated with smoking. Provide up to date information for teachers, parents and governors about all aspects of smoking and tobacco related issues.

Focus of service/intervention: Smoking cessation and prevention

Brief description of service/intervention: Healthy Schools Drugs education Co-ordinators works with mainly with PSHE teachers in both primary and secondary schools in Cumbria. Co-ordinators helps to provide them with local statistics, information and up-to-date resources regarding smoking which they can use in their personal, social, health and economic wellbeing lessons. In order for a school to achieve their Healthy Schools status they must have achieved certain criteria such as using current data to support programmes of study, having up to date policies, eg No Smoking policy, and linking schools to outside agencies and referral services. The co-ordinators also deliver sessions about drug and alcohol awareness, including a section on smoking, for parents and governors in schools.

Advocacy elements: (none specified)

Location of delivery: schools, community centres and outreach

Target population: Adults, children and young people, pregnant women (smokers and non smokers)

Targets that work is actively monitored towards:

NATIONAL:

LOCAL: In Cumbria we aiming to have over 75% schools achieving Healthy Schools status by December 2009

Evidence of effectiveness: The high number of schools in Cumbria who have achieved their healthy schools status is an indication that most young people in Cumbria are receiving a thorough education about smoking.

Every 2-3 years a Health Related Behaviour questionnaire is conducted with approx 2000 secondary school pupils throughout Cumbria. The results of the most recent one are soon to be published and will show if there has been a reduction in the number of young people taking up smoking.

Costs: (none provided)

Funding: (not applicable)

Staffing: In the Cumbria Healthy schools team there are five co-ordinators who have responsibility for different areas of the Healthy Schools programme eg food and nutrition and drugs education.

Stop Smoking Service and Tobacco Control

Geographical area: Halton & St Helens

Contact: Tisha Baynton

ADDRESS: Tobacco Control, Health Improvement Team, Suite1E, Midwood House, Midwood Street, Widnes, WA8 6BH

EMAIL: Tisha.baynton@hsthpcpct.nhs.uk

TEL: 01928593085

Aims and objectives: (none provided)

Focus of service/intervention: Smoking cessation and prevention and tobacco control;

Brief description of service/intervention: Working within 5 key areas: cessation; prevention; de-normalising; illegal and counterfeit and marketing. One to one and group smoking cessation sessions in community settings and venues delivered by specialists during working hours and out of hours. Voucher scheme in operation for NRT. Other products via GP prescription. Intermediate cessation delivered by Practise Nurses and pharmacists. 'Stop before your Op' scheme in local hospital. Stop Smoking Service Specialist Midwives. Education on Tobacco Control in Schools via drama workshops, Teacher workshops and classroom inputs. Peer mentoring initiative underway. Partnership working with Environmental Health, investigating opportunity to deliver smoke free home scheme via fire service.

Advocacy elements: National Tobacco Control consultation received over 3,000 responses. Investigating opportunities in schools and colleges to set up local youth advocacy group.

Location of delivery: schools, GP surgery, clinic and hospitals, community centres, church halls and outreach, internet (appointments available via local website).

Target population: Adults, children and young people, pregnant women (smokers and non smokers)

Targets that work is actively monitored towards:
 NATIONAL: Smoking kills white paper. Beyond smoking kills
 LOCAL: Champs (Cheshire & Merseyside) strategy; LAA Target; Commissioning Service Plan, National Indicators; NST Review Findings

Evidence of effectiveness: (none provided)

Costs: (none provided)

Funding: (not applicable)

Staffing: 1 Stop Smoking Service Manager; 2 Part time education Advisors; 1 full time education Advisor; 8 WTE Stop Smoking Service Advisors; 3 WTE Administrators; 2 Specialist Midwives; 1 Tobacco Control Specialist; Practise Nurses in Halton; 13 Pharmacies across Halton & St Helens

Social marketing mass media campaigns aimed at young people

Geographical area: Sefton

Contact: Cathy Warlow

ADDRESS: 1st Floor Burlington House, Crosby Road North, Waterloo L22 0QB

EMAIL: cathy.warlow@sefton.nhs.uk

TEL: 0151 479 6550

Aims and objectives: To raise awareness of the health and lifestyle consequences of smoking to young people; to reduce the uptake of smoking by young people; to increase uptake of smoking cessations services by young people.

Focus of service/intervention: Smoking cessation and prevention

Brief description of service/intervention: A range of media campaigns based on the principles of social marketing have been undertaken within the borough to specifically target young people. The content of the campaigns have been developed in partnership with young people and campaigns have been developed to target females and males. A variety of resources have been developed to support the campaigns including bus shelter posters, posters, credit cards and other promotional materials such as pencils. These resources have been targeted to areas within the borough that have the highest smoking rates and have been distributed to a variety of venues where young people congregate such as cafes, cinemas, leisure centres, schools and colleges in addition to standard health care routes. More detailed information on each campaign can be found in the evaluation reports in appendix D, E and F.

Advocacy elements: These campaigns have been supported with school resources to support health education lessons along with the commissioning of the 'whatever' play to advocate to young people the dangers of smoking, and to highlight to them where they can get help to quit.

Location of delivery: schools, GP surgery, clinic and hospitals, community centres, and media formats. Resources and materials are distributed to a wide range of settings where young people congregate

Target population: Young people,

Targets that work is actively monitored towards:
 NATIONAL: 4 week quit rates

LOCAL: Local referrals to the stop smoking service. Local Area Agreement (LAA) targets
Evidence of effectiveness:Data from the Tell Us Three Ofsted survey has also demonstrated that for 2007-2008 the number of young people never smoked has increased from 71% to 73%.

Costs: £25,000 per annum

Funding: (not applicable)

Staffing: Two full time members of staff. Health Promotion Specialist: Tobacco Health Promotion Officer: Tobacco. Assistance of PCT graphic designer

Sefton Smokefree Homes

Geographical area: Sefton

Contact: Cathy Warlow

ADDRESS: 1st Floor Burlington House, Crosby Road North, Waterloo L22 0QB

EMAIL: cathy.warlow@sefton.nhs.uk

TEL: 0151 479 6550

Aims and objectives: Sefton Smokefree Homes is a project set up to encourage families and households of both smokers and non smokers to make their home a smokefree environment. By pledging to become a smokefree home householders are providing a safe and pleasant environment for themselves, their families and their friends

Focus of service/intervention: Smoking cessation and prevention

Brief description of service/intervention: For the public to pledge their commitment to make their home totally smokefree they are required to fill in an application form which is attached to the smokefree homes literature and return it to the service using the free post envelope provided. Once the application is received a certificate is sent out to confirm their pledge and a resource pack is included to support the participants in maintaining their commitment to this project.

A pilot of this intervention highlighted that the large majority of pilot respondents were recruited to the scheme via health professionals. To encourage health professionals to distribute the literature the intervention is now promoted to various health professionals such as midwives, health visitors and children centre employees through the Merseyside reducing children's exposure to secondhand smoke training course. Smokefree homes literature is also included in birth packs distributed through the maternity units.

Advocacy elements: (none specified)

Location of delivery: schools, GP surgery, clinic and hospitals,

Target population: Adults

Targets that work is actively monitored towards:(none specified)

Evidence of effectiveness:(none specified)

Costs:(none specified)

Funding: (none specified)

Staffing: (none specified)

Appendix C: Sefton Support NHS Stop Smoking Service:Progress to target 07– 08

Sefton	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Target for year LAA 2228	557	557	557	557
Total Setting quit date	1140	1420	1096	1324
4 week Successful quits	502	699	515	683
Success rate	44%	49%	47%	52%
Towards target	502	1201	1716	2399
Percentage toward target	22%	54%	77%	108%
Men set quit In Sefton	413	521	439	533
Men quit at 4 weeks	194	263	222	283
Success rate	47%	51%	51%	53%
Pregnant set quit in Sefton	48	43	24	47
Pregnant quit at 4 weeks	14	16	7	21
Success rate	30%	37%	30%	45%

working for eg School Health, Children Services, Children Centres, Maternity Services.

Appendix D: Social marketing mass media campaigns aimed at young people: Sefton



Jo McCullagh, Health Promotion Specialist, SHISS

Purpose of Campaign

Smoking is the largest preventable cause of ill health and premature death in the UK population. It kills around 120,000 people every year, equating to more than 300 every day and around half of all smokers will eventually be killed by their habit (ASH, 2004). Local evidence illustrates that smoking rates among young women in Sefton are increasing, with a recent study showing that nearly a third (29%) of women aged 15-34 years in the Borough regularly smoke (South Sefton PCT, 2005).

In response, this media campaign was developed to prevent young women from initiating smoking and to motivate those who smoke to quit their habit. A variety of resources including bus shelter posters (21), A4 posters (2,000), and coasters (10,000) were distributed across Sefton NRF areas during November and December in line with the build up to the Christmas party season. To compliment National campaign strategy (Smoking Kills...Your Chances of Getting A Date, Department of Health, 2006) this focused on the unattractive elements of smoking including bad breathe, stained teeth and longer-term issues such as the development of facial wrinkles, concerns specific to a female audience. The publicity materials were purposely targeted to a total of 700 venues where young women congregate including:

- Hairdressers and Beauty Salons
- Sunbed Centres
- Tattoo and body piercing parlours
- Pubs and Clubs
- Cafes, chip shops and fast-food outlets
- Off licences
- Clothing, cosmetic and music retail outlets
- High Schools
- Colleges
- Train stations

In addition to the standard distribution routes:

- GP surgeries
- Health clinics
- Pharmacies
- Healthy Living Centres
- Children's centres

Outcomes

The initiative aimed to:

- Improve engagement of the local community, health care profession and business sector in public health and healthier lifestyle promotion.
- Raise awareness of the health and lifestyle consequences of smoking and the availability of stop-smoking services.
- Increase female referral to stop-smoking services and quit rates among young women.

Evaluation

A short evaluation questionnaire was distributed with the materials to assess participant's use and satisfaction levels with the campaign. Unfortunately, only seventeen were returned. Therefore, given the small number of participants, care must be exercised in any generalisations from the findings:

- All seventeen organisations used the materials, which they located in their reception areas (5), in the shop itself (4), consultation rooms (3), restaurants (2), changing and restrooms (4) and allocated smoking areas (1).
- The majority rated the resources as useful (10) or very useful (4). Three agencies was uncertain.
- On average, participants found the materials informative (13/17), interesting (13/17), thorough (13/17) and clear (15/17):
- Only one respondent wanted additional information to be incorporated into the resources, which related to behavioural tips to give up smoking.
- Five agencies had received feedback from the public on the resources, all of which had been favourable:

"They have contacted the free phone number."

"Customers have taken the phone number."

"The general response has been "About time!"

- The majority of responding agencies (13/17) wanted to receive further smoking cessation resources and all but one wanted to participate in future campaigns.

In addition, demographic analysis of NRF referrals accessing the local NHS smoking cessation service, SUPPORT illustrates a five-fold increase in the number of young people using the service following the campaign – In December 2006, 23 individuals aged 35 years and under referred to SUPPORT compared to 116 in January and 68 in February 2007.

References

ASH. *Smoking and Disease*. London : ASH, 2004.

South Sefton PCT. *Sefton-wide Lung Cancer Equity Audit*. July 2005

Appendix E: Social marketing mass media campaigns aimed at young people: Sefton

‘Pucker up don’t light up’ campaign evaluation

Smoking is the leading cause of preventable death and ill health in the UK, with half of all regular cigarette smokers eventually being killed because of their addiction (Peto 1994). Smoking among young people is a particular concern, it is estimated that 450 children start smoking everyday. This is extremely pertinent given the fact that the earlier a person starts smoking the greater the risk of developing lung cancer and heart disease.

Smoking prevalence rates in Sefton highlight the need to focus smoking cessation towards young people as high rates are found amongst young women in the borough. In response to this Sefton Primary Care Trust developed a new stop smoking campaign to encourage young girls to stop smoking and to raise awareness of the local stop smoking service SUPPORT.

During the development of previous campaigns it has consistently shown that young girls are motivated by stop smoking messages that focus on how smoking affects their appearance and attractiveness compared to campaigns that focus on the health implications. As such Sefton Primary Care Trust designed a stop smoking campaign to coincide with Valentines Day called ‘pucker up don’t light up’ to demonstrate how smoking can affect a person’s attractiveness.

The design and content of this campaign was developed in consultation with young people in the borough, and a variety of methods were used to promote the campaign, including:

- Bus shelter posters
- Internal bus adverts
- A4 posters
- Credit Cards

These were distributed across Sefton NRF areas during February to coincide with Valentines Day.

The publicity materials were targeted to a total of 348 venues frequented by young women such as cinemas and beauticians as well as standard health settings such as GP’s and dentists.

To evaluate this campaign all venues that received the resources were asked to complete a short evaluation form rating the design and content of what they had received.

Method

All establishments that received campaign resources also received an evaluation form. The form consisted of 12 questions and used a range of rating scales, along with open and closed

questions. Only 17 responses were received in total (a response rate of 4.8%) and so generalisations cannot be made from the results.

Results

All 17 respondents used the resources they had received and had displayed them in a range of places such as staff rooms, toilets and public areas. The majority of respondents rated the resources as useful or very useful.

Participants were asked to rate the design of the resources on four criteria using a five point likert scale. Participants found the resources informative (3.7), interesting (3.4) clear (3.9) and through (3.5).

One respondent commented that they had received feedback from the public on the resources stating

'Mostly comments from young men saying they wouldn't kiss her'

Five respondents stated that they would have liked to have seen further information included within the resources these included:

'Information about the Allen Carr clinics, books etc'

'Dangers of smoking needs more emphasis'

'Shocking health implications'

'More written information'

Discussion

Smoking prevalence rates and previous research findings has highlighted a great need to target young people to both prevent uptake and to encourage young smokers to quit. The 'pucker up don't light up' campaign aimed to increase awareness of the stop smoking service and encourage cessation and prevent uptake of smoking, by informing young people of the effect smoking has on appearance. The evaluation results indicate that the resources were widely displayed across the borough as they were displayed by all of the respondents. The resources were also rated as useful and so have raised the profile of the local stop smoking service across a wide range of workplaces and community venues.

The venues chosen to receive the resources were chosen in consultation with young people in the borough as well as the design and content of the resources themselves. Overall the

focus groups rated the campaign positively which has been reflected in the results from the evaluation questionnaire.

There were five respondents who felt that more written information on the health risks from smoking should be included. As the campaign was developed with young girls who stated that health based messages do not motivate them to quit it was decided that information shouldn't be included in the poster. Information on the risks to health was included on an information postcard that accompanied this campaign.

In conclusion this campaign has been well received by both young people and services used by young people alike this has been reiterated by one respondent

'Thank you very much, the resources we receive on giving up smoking are always used and appreciated'

Recommendations

- Future campaigns should continue to be developed in consultation with the target audience
- Supporting information should be provided that covers the health risks associated with smoking

Appendix F: Social marketing mass media campaigns aimed at young people: Sefton

Kick Your Habit and Think Hard Campaign Evaluation

Local data demonstrates that smoking rates among males is higher than females in Sefton. With 19.7% of Sefton men smoking regularly compared to 16.5% of women (Sefton lifestyle survey 2007). Not only are more local men smoking but they are also less likely to access SUPPORT Sefton's local NHS stop smoking service. Assessments of clients who access the service have shown that between April 2007 and March 2008 only 36.4% were men.

Previous research has found that media campaigns can have a strong potential to help reduce morbidity and mortality associated with cigarette use (Friend and Levy 2002). Campaigns conducted in Sefton have also supported these findings with campaigns contributing to the increasing the awareness of the local stop smoking service SUPPORT (Sefton Citizens Panel 2008).

To address the high prevalence rates and low uptake of the service by local men Sefton Health Improvement Support Service developed two local campaigns, 'Kick your habit' and 'Think hard'. These campaigns were developed in partnership with 19 local men who wanted the campaigns to focus on the negative effect smoking can have on sports performance and on the increased risk of impotence. To publicise these campaigns bus shelter advertising along with specific campaign resources were developed and targeted to areas that have the highest smoking rates along with over 200 worksites and community venues where young men are likely to spend time. These included

- Youth clubs
- High schools
- Colleges
- Pubs
- Leisure centres
- Sports clubs
- Betting shops

The resources were also distributed to standard health care settings such as GP's and pharmacies.

Method

To further evaluate this campaign and to assist the development of future resources, all campaign materials were accompanied with a short evaluation form. This questionnaire aims to gain the views of the agencies that receive the resources and see if they have received feedback from the public. The form consisted of 12 questions gaining both qualitative and quantitative data and utilised a range of rating scales.

Only ten responses were received in total and so generalisations cannot be made from these results.

Results

The results from this evaluation demonstrate that all respondents had used the resources within their setting with six of the respondents rating the materials as useful. Participants were asked to rate the resources on a five point likert scale on four different criteria. If a participant gave a score of five this indicated that the participants rated it strongly against the criteria. The results from this question indicated that the participants rated the information on the resources as informative (4) interesting (4) clear (4) and through (3).

It should also be noted that information elicited from the questionnaire showed that all participants would like to participate in future campaigns, with all but one participant wanting to receive future stop smoking resources.

Conclusion

Future campaigns have previously been successful in increasing the number of people accessing the local stop smoking service SUPPORT. The results of this campaign have been positive showing that they have been informative and interesting to the people and agencies that have received them. The results from this evaluation support the findings of the focus groups that had previously been undertaken to develop the campaign resources themselves.

The results of this evaluation have indicated that the campaign materials are informative to young men about the effects of smoking and deliver this information in an interesting way, ensuring that they would be seen by our target audience.

Recommendations

- Campaigns should continue to be targeted to specific audiences and continue to be developed in consultation with the target audience.
- The report should be updated with referral data from SUPPORT on the number of you men accessing the service when this is available.

Appendix G. Supplementary information to the evidence review

Table 8. Reducing exposure to second hand smoke

Author(s)	Years included	Inclusion	Number of studies	Results
Gehrman & Hovell 2003	NR	Published articles that examined ETS interventions for children from birth through adolescence, targeting household members	19 studies; 12 RCTs, 5 controlled trials and 2 quasi-experimental studies.	Overall 11 studies reported significant reductions in ETS. Of twelve randomised controlled trials, eight studies reported statistically significant effects on ETS exposure (mean effect size $d=0.38$). The data suggested that home-based interventions may be particularly promising and that interventions delivered in healthy populations may be as efficacious as interventions in sick children.
Hopkins et al 2001	1980 to May 2000	Studies had to: (i) address at least one area in the conceptual framework i.e. ETS, initiation or cessation; (ii) primary study; (iii) take place in an industrialised country or countries; (iii) English language; (iv) report one or more outcomes of interest; and (v) include a non exposed comparison group.	1 study	Community education to reduce exposure to ETS in the home: Insufficient evidence because of the small number of available studies and limitations in the design and execution of available studies.
Priest et al 2008	Inception to Oct 2007	Controlled trials with or without random allocation that examined mechanisms for reduction of children's ETS exposure, and smoking prevention, cessation and any other tobacco control programmes targeting parents and other family members, child care workers and teachers involved with care and education of infants and young children (0-12 yrs).	36 studies; 4 community level, 16 delivered to parents in 'well child' settings, and 13 targeted parents in 'ill child' settings.	Eleven studies reported success in achieving reduced children's ETS exposure between intervention and control groups. Four studies were conducted in or from a clinical setting and employed a comprehensive counselling approach. Individual studies reported evidence of success for the following types of interventions: a school-based curriculum approach; intensive home visiting programme for at-risk mothers that included education about preventive child health; smoking cessation telephone counselling to mother recruited through 'well child' clinics; the provision of brief educational information to parents of sick children in a clinical setting; education provided by nurses to mothers attending 'well child' visits about the impact of smoking on either their own or their child's health; health advice provided to mothers of sick children. The authors concluded that there is currently insufficient evidence to recommend one strategy over

Author(s)	Years included	Inclusion	Number of studies	Results
				another to reduce the prevalence or level of children's environmental tobacco smoke exposure. They suggest that there is limited support for more intensive counselling interventions delivered to parents. There is greater support for interventions concentrating primarily on changing participants' attitudes and behaviours, rather than on changing knowledge.
Thomson et al 2006	Up to March 2005	Studies that examined the effectiveness, reduction in inequalities, or cost-effectiveness of population level approaches to reduce the prevalence of home SHS. Limited to studies from USA, Australia, New Zealand and Britain.	Not clear	Four population based policy options were identified: comprehensive programmes, policies that change public knowledge and actions on SHS, mass cessation programmes, and structural options. The only population level option for which the authors found direct evidence of an association with the prevalence of smokefree homes, or evidence of a reduction in inequalities was comprehensive tobacco control programmes (defined as those that at a minimum included active tobacco price policies, effective education, smokefree place policies, and population level cessation support). The authors identified indirect evidence for the effects of mass media campaigns and mass cessation programmes.

RCT – Randomised Controlled Trial; ETS – environmental tobacco smoke

Table 9. School-based programmes

Author(s)	Years included	Inclusion	Number of studies	Results
Fletcher et al 2008	Up to March 2006	Intervention studies were eligible if they included a comparison group and longitudinal data; studied whole school interventions aimed at reducing drug use among young people aged 11-16; and measured drug use at follow-up. Observational studies were eligible if they used a longitudinal design, reported exposure as a measure of either school-level factors or individual-level school-related attitudes or behaviours, and measured drug use at follow-up.	Four intervention studies and nine observational studies.	Three studies reported rates of smoking separately. All three suggested that the intervention examined had a protective effect. The authors concluded that action to improve school ethos and support student engagement can have positive effects in reducing drug use.
Kavanagh et al 2006	1985 to April 2005	Studies that evaluated the impact of incentive interventions on health, education or other social outcomes, and targeted groups or individuals aged 11-19 years.	16 studies; three studies focused on smoking behaviour	Pooling data from all three studies showed that incentives had no overall effect (RR 1.04; 95% CI 1.00, 1.08). The authors conducted a sensitivity analysis and pooled the results of the data taken from the two school-based anti-smoking competitions. The intervention had a statistically significant and positive impact on reported daily smoking rates at the first follow up (RR 1.06; CI 1.03, 1.09) and at the second follow up at one year (RR 1.05; CI 1.02, 1.08).
Müller-Riemenschnieder et al 2008	Aug 2001 to Aug 2006	German and English literature targeting youth up to 18 years. RCTs were included if they were of a duration of at least 12 months and reported smoking behaviour.	35 studies	School-based (14 studies): Two studies of good/high methodological quality reported positive intervention effects, the results of the seven remaining good/high quality studies were inconclusive or unfavourable. Results of meta-analysis provided no evidence of long-term effectiveness of school-based interventions. Community-based (10 studies): Estimated pooled effects provided some evidence for the long-term effectiveness of community-based interventions. Multisectorial (11 studies): Meta-analysis provided strong evidence of the effectiveness of the intervention.

Author(s)	Years included	Inclusion	Number of studies	Results
				The authors reported that the review revealed the evidence for the effectiveness of school-based interventions to be inconclusive, whereas the evidence for the effectiveness of community-based and multisectorial interventions was somewhat stronger. Some evidence for the additional effectiveness of approaches which incorporate family-based intervention.
Thomas & Perera 2008	Inception to Oct 2005	RCTs that examined school-based programmes that had as one of their goals deterring tobacco use among children (aged 5-12) and adolescents (aged 13-18) in school settings.	94 RCTs were eligible for inclusion.	<p>(1) Information-giving curricula vs. control: Two studies provided information on short-term prevention. One study reported that at 12 months the in-school group were less likely to continue to smoke compared to control (OR 0.49; 95% CI: 0.29, 0.84) and at 18 months were less likely to start smoking compared to control (OR 0.42; 95% CI: 0.018, 0.96).Crone 2003 reported a significant effect of the intervention that they examined (OR 0.61; 95% CI: 0.41, 0.91). *potential bias in results.</p> <p>(2) Social competence interventions vs. control (3 RCTs): A non-significant positive effect was obtained from the pooled estimate (OR 0.77; 95% CI 0.48, 1.22).</p> <p>(3) Social influences intervention vs. control: 13 studies provided information on short term prevention and 7 on long term prevention. A non-significant positive effect on short-term prevention was obtained from the pooled estimate (OR 0.93; 95% CI 0.84, 1.03); while a non-significant negative effect on long term prevention was obtained from the pooled estimate (OR 1.19; 95% CI 0.99, 1.42). There was some evidence of heterogeneity among the studies combined on long term prevention. Study quality did not affect the results in sensitivity analyses.</p> <p>(4) Combined social competence and social influences vs. control: 6 studies provided information on short term prevention and 1 on long term prevention. A non-significant positive effect on short term prevention was obtained from the pooled estimate (OR 0.72; 95% CI 0.45, 1.16); while the only trial on long term prevention reported a non-significant positive effect (OR 0.55; 95% CI: 0.30, 1.01).</p> <p>(5) Multi-modal programmes compared to single-component interventions (9 RCTs): Three studies reported positive</p>

Author(s)	Years included	Inclusion	Number of studies	Results
				significant results.
Wiehe et al 2005	Inception to July 2003	RCTs that followed students from the time of intervention to at least 12th grade or age 18, at least 1 year after the intervention ended. Studies were included if they measured smoking prevalence as a primary outcome.	8 studies	Smoking prevalence as reported in each study at 12th grade or age 18 follow-up evaluation varied from 15% to 58% in the intervention groups and from 15% to 52% in the control groups. Five studies used current smoking as a primary outcome. None of the differences were statistically significant in any individual study except for Botvin et al. The pooled risk difference estimate from the random effects meta-analysis was -0.61 (95% CI -4.22, 3.00). Statistical tests indicated heterogeneity in the pooled estimate.
RCT – Randomised Controlled Trial; RR – Relative Risk; OR – Odds Ratio				

Table 10. Community-based programmes

Author(s)	Years included	Inclusion	Number of studies	Results
Bruce & van Teijlingen 1999	1988 to 1997	Published or unpublished evaluation of Smokebusters, a community-based initiative for children.	36 interim and final reports were identified, however only three clubs measured outcome evaluation.	"The evidence from the three outcome studies suggests that Smokebusters does improve childhood knowledge and awareness of the hazards of smoking but does not alter smoking prevalence in children... to date, there is not enough evidence to suggest that the intervention is an effective one in terms of reducing smoking."
Christakis et al 2003	Jan 1966 to July 2002	Controlled trials of smoking prevention interventions delivered by healthcare providers and targeting youth (aged <21 years). Restricted to English language publications.	4 trials; 2 in dental/orthodontic settings and 2 in primary care settings.	Three studies found no significant differences between treatment and control groups with respect to initiation of smoking during the follow-up period. A small but significant reduction in smoking among intervention youth was found in a study which examined the provision of age-related materials detailing the advantages of remaining a non-smoker every 3 months for 1 year; 5.1% of the intervention group and 7.8% of the control group reported smoking at 12-months follow-up (OR 0.63; 95% CI 0.44, 0.91).
Sowden & Stead 2003	Up to Sept 2002	Any controlled study which evaluated the effectiveness of community interventions in the prevention of smoking in young people aged less than 25 years. Relevant interventions included those targeted at entire or parts of entire communities or large areas with the intention of influencing the smoking behaviour of young people. Community interventions are defined as co-ordinated, widespread programmes in a particular geographical area (e.g. school districts) or region or in groupings of people who share common interests or needs, which support non-smoking behaviour.	17 studies.	Twelve evaluations compared community-wide interventions with no intervention controls. Two studies, which were part of larger community-wide cardiovascular disease prevention programmes targeted at all age groups (the Minnesota Heart Health Program and the North Karelia Youth Project), reported differences in smoking prevalence between the intervention and control groups. Four studies compared community-wide interventions with controls who received a school-based intervention only. Only one study (Project SixTeen) reported statistically significant differences in self-reported smoking prevalence (from baseline) between the intervention and control groups (although no significant differences were found between groups based on samples of expired air carbon monoxide). In a comparison of the effectiveness of a community-wide intervention which included a school-based component with the community-wide intervention without the school-based component, no differences in smoking rates between the two groups were found but smoking prevalence decreased in both groups from baseline to follow-up. In one study that compared a community-wide intervention including a mass media component with a control which received

Author(s)	Years included	Inclusion	Number of studies	Results
				only the media component, smoking rates increased in both groups from baseline. However the rate of increase in the intervention group was significantly lower than in the control group.
OR – Odds Ratio				

Table 11. Family-based programmes

Author(s)	Years included	Inclusion	Number of studies	Results
Petrie et al 2007	Up to Oct 2003	RCTs, controlled trials and CBA studies were eligible for inclusion. 'Parenting programmes' were defined as any intervention involving parents with children <18 years of age, which was designed to develop parenting skills, improve parent/child communication or enhance the effects of other interventions.	20 studies; 16 RCTs, 3 CBAs, and 1 CT.	Many of the studies reviewed had complex interventions of which a parenting programme was only one component. Four studies involved primary school children aged 5–11 years, eight studies targeted children at the change from primary (elementary) to secondary (middle and high school) education, and eight studies looked at interventions with teenage children and their parents. The authors considered the strongest evidence to be based on work that had been undertaken with preteen and early adolescent children. Seven studies, rated good or fair quality, reported that the parenting programme evaluated led to a significant reduction in one or more of the outcome variables measured, including tobacco use, compared with controls. Three of these studies had examined the Iowa Strengthening Families Programme and the Preparing for the Drug Free Years programme. The authors identified that effective interventions (i) emphasized development of social skills and sense of personal responsibility among young people, as well as addressing issues related to substance use and (ii) included active parental involvement.
Thomas et al 2007	NR	Studies were included in which students and/or family members were randomised to receive interventions with children and family members intended to deter the use of tobacco or be in the control group.	22 RCTs	Six of the included RCTs were rated to have a minimal risk of bias, and three found positive effects of family interventions. Of the ten RCTs rated to have a moderate risk of bias, three found positive intervention effects and one found negative effects. Intensity of training and fidelity of implementation seemed to be associated with more positive outcomes. The authors concluded that it was not possible to draw firm conclusions from the current evidence base about the efficacy of family interventions to prevent adolescent smoking.

RCT – Randomised Controlled Trial; CBA – Controlled Before and After; CT – Controlled Trial

Table 12. Mass media

Author(s)	Years included	Inclusion	Number of studies	Results
Sowden 1998	Up to 1998	Randomised controlled trials, controlled trials without randomisation and time series were eligible for inclusion if they evaluated the effectiveness of mass media campaigns in influencing the smoking behaviour in young people aged <25 years. Mass media was defined as channels of communication such as television, radio, newspapers etc.	6 studies	Three studies examined mass media alone, and three studies used mass media together with school-based components. The majority of interventions were based on the social influences approach, but the intensity and duration of the programmes varied. Two of the six interventions were associated with reductions in smoking behaviour. One study found that a mass media campaign including newspaper advertisements, posters, TV and cinema spots every 3 months over 3 years was effective in influencing smoking behaviour compared with no intervention (smoker: OR 0.74; 95% CI: 0.64, 0.86). A second study found that a mass media campaign (TV and radio messages broadcast over a 4 year period) combined with a schools-based programme teaching refusal skills and skills to resist advertising pressure was more effective than a schools-based programme alone (weekly smoking at two years follow-up: OR 0.62; 95% CI 0.49, 0.78). Both interventions were similar in terms of their intensity and duration, lasting 3 and 4 years, respectively.
Hopkins et al 2001	1980 to May 2000	Studies had to: (i) address at least one area in the conceptual framework i.e. ETS, initiation or cessation; (ii) primary study; (iii) take place in an industrialised country or countries; (iii) English language; (iv) report one or more outcomes of interest; and (v) include a non exposed comparison group.	12 studies	Strong scientific evidence exists that mass media campaigns are effective in reducing tobacco use prevalence in adolescents when combined with other interventions.

OR – Odds Ratio

Table 13. Smoking cessation programmes for young people

Author(s)	Years included	Inclusion	Number of studies	Results
Garrison et al 2003	Up to June 2002	Controlled trials of smoking-cessation interventions conducted in adolescent smokers (aged 10 to 21 years) and published in the English language.	6 studies, 3 school-based programs, 1 hospital-based, 1 with pregnant adolescent females, and 1 used laser acupuncture as the intervention.	All three school-based studies reported significant impacts on cessation rates, included one randomised trial. The remaining two studies showed no difference between intervention and control groups in smoking outcomes.
Grimshaw & Stanon 2006		Randomised controlled trials, cluster-randomised controlled trials and controlled trials. Young people aged less than 20, who were regular tobacco smokers. A broad range of intervention types were eligible if they were cessation programmes. The primary outcome measure was smoking status at six months follow-up, among those who smoked at baseline.	15 trials	Transtheoretical model of change (TTM) (n=3 studies): Interventions based on the TTM had moderate long-term success at one year (pooled OR 1.70; 95% CI: 1.25, 2.33) persisting at two years follow up (OR 1.38; 95% CI: 0.99, 1.92). Pharmacotherapy (n=2 studies): Both studies were small scale with low power to detect an effect. Neither trial demonstrated statistically significant results. Psychosocial interventions (n=9 studies): Three studies used motivational interviewing, but none demonstrated effectiveness. Also five trials that examined cognitive behavioural therapy interventions did not individually achieve statistically significant results; although pooling three trials based on the "Not on Tobacco" intervention suggested that this intervention may be effective (OR 1.87; 95% CI: 1.00, 3.50).
Sussman et al 2006	1970 to Dec 2003	Any article or report in the English language that included data regarding the contents of a teen smoking cessation effort, quit rates, and a through-study age range of 12 to 19 years old. Only studies that included a control condition were selected.	48 controlled trials were in the primary analysis.	The overall treatment effect size was estimated at 2.90% (SE 0.73%, p = 0.0003). The average quit rate for the controls was 6.24% (SE 1.06%), and the average treatment quit rate was 9.14% (SE 1.12%). The treatment net effect size was statistically significant for intermediate (0–3 months: 3.91%; ±0.93%), middle-term (4–12 months: 2.92%; ±1.12%), and long-term (longer than 12 months 6.62%; ±1.14%) follow-ups. Motivation-enhanced programs (15 studies: net treatment effect 3.66%; SE 1.25%; p<0.01), cognitive– behavioural programs (17 studies: net treatment effect 4.72%; SE 1.20%; p<0.01), and social influence programs (8 studies: net treatment effect 3.77%; SE 1.22; p<0.01) all demonstrated significant effects. In addition, classroom (7 studies: net treatment effect 4.15%; SE 1.19;

Author(s)	Years included	Inclusion	Number of studies	Results
				<p>p<0.01) and school clinic (25 studies: net treatment effect 5.62%; SE 1.05%; p<0.001) modalities produced significant effects. Programmes with fewer than five sessions failed to find a program effect (17 studies: net treatment effect -0.08%; SE 0.36%). Conversely, programs with more than four sessions showed a 5% increase in quit rate compared with controls. (5–8 sessions: net treatment effect 6.43%; SE 1.28%; p<0.001 and 9 or more sessions: net treatment effect 4.51%; SE 1.00%; p<0.001)</p>

Table 14. Smoking cessation programmes for pregnant women

Author(s)	Years included	Inclusion	Number of studies	Results
Dennis & Kingston 2008	Up to 2006	RCTs of telephone-based supportive interventions in which the primary aim was to reduce the risk of adverse health outcomes for women and their infants related to smoking, preterm birth, low birthweight, breast feeding and postpartum depression. Eligible studies included pregnant women and new mothers within the first 2 months postpartum.	14 trials	Various types of telephone support had no overall effect on smoking abstinence, smoking relapse or cessation rates among pregnant women or mothers in their first year postpartum. Telephone support in combination with home visits or other face-to-face sessions had a beneficial effect on smoking abstinence (2 trials; RR 1.77; 95% CI 1.13, 2.77) and on relapse (one trial; RR 0.71; 95% CI 0.52, 0.96).
Levitt et al 2007	Up to 2005	RCTs of interventions pertaining to postpartum smoking cessation, smoking reduction and relapse prevention, initiated immediately after birth to 1 year in postpartum women which were conducted in North America, Europe, Australia or New Zealand.	Three trials	The review showed no effect of advice materials and counselling interventions in hospital, paediatricians' offices, or child health centres on cessation rates, relapse prevention or smoking reduction in the postpartum period. However, the interventions did show some positive effects on women's readiness to stop smoking and confidence in preventing relapse and self-efficacy. The authors concluded that there is currently no evidence to support the implementation of postpartum smoking cessation interventions.
Lumley et al 2004	Up to July 2003	Studies with randomised or quasi-randomised allocation which examined smoking cessation programmes implemented during pregnancy.	64 trials	Pooled data from 48 trials revealed a significant reduction in continued smoking in late pregnancy in women participating in smoking cessation programmes (RR 0.94; 95% CI 0.93, 0.95) which equated to an absolute difference of 6% in the proportion smoking. (Significant heterogeneity among these trials and in subsequent comparisons of biochemically validated studies, high quality studies and high intensity studies). When trials were grouped according to intervention type, cognitive behavioural therapy showed a similar pooled effect (RR 0.95; 95% CI 0.92, 0.97). Trials using "stages of change" theory did not demonstrate effectiveness (RR 0.98; 95% CI 0.94, 1.01) nor did trials using feedback (RR 0.92; 95% CI 0.77, 1.11). Three trials of NRT indicated borderline effectiveness (RR 0.94; 95% CI 0.89, 1.00). Two trials that included a social support and a reward component

Author(s)	Years included	Inclusion	Number of studies	Results
				showed a significant effect (RR 0.77; 95% CI 0.72, 0.82). The authors concluded that smoking cessation programmes need to be implemented in maternity care settings.
Naughton et al 2008	Up to Feb 2006	Controlled trials with a randomised or quasi-randomised allocation including pregnant smokers at any stage of care aged 16 years and over. At least one of the experimental arms had to meet the self-help definition used by the authors.	15 trials; 12 compared either one or two self-help arms with usual care and three compared a self-help with self-help	<p>Usual care generally consisted of routine advice to quit smoking and the provision of brief written materials. Self-help intervention consisted of booklets (6 studies), videos (two studies), and booklet-based with additional components: a computer-tailored programme (one study); an audiocassette (one study); written prescriptions and letters of encouragement from health professionals (one study); and medical letters, a 'buddy' advice letter and tipsheet, quarterly newsletter and additional information leaflets (one study).</p> <p>Usual care vs. self-help (12 studies): Pooled OR = 1.83 (95% CI: 1.23, 2.73; I-squared = 61.9%). Equates to an absolute difference between groups of ~5%. Subgroup analysis of 11 trials found self-help booklet intervention more efficacious than usual care (pooled OR = 1.67; 95% CI: 1.14, 2.44; I-squared = 59.35%). No significant difference between interventions providing brief or no contact and those providing extended contact. Findings were robust to removal of studies in the sensitivity analyses.</p> <p>Self-help vs. more intensive self-help (7 studies): No significant difference between self-help and more intensive self-help (OR 1.25; 95% CI: 0.81, 1.94; I-squared = 27.9%) or between non-tailored self-help interventions and self-help intervention tailored to participant characteristics (OR 0.95; 95% CI: 0.60, 1.48; I-squared = 0%). Findings were robust to removal of studies in the sensitivity analyses.</p>

Table 15. Reducing underage access to tobacco

Author(s)	Years included	Inclusion	Number of studies	Results
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Stead & Lancaster 2005	Up to April 2008	RCTs, non-randomised controlled trials, time series studies, and uncontrolled before and after studies that examined measures to improve compliance with laws restricting youth access to retail sales of tobacco. Interventions considered included education, law enforcement, community mobilisation, or combinations of strategies that aimed to deter retailers from selling tobacco to minors (defined by the legal age limit in the communities studied).	35 studies.	The main intervention types examined were education about legal requirements, notification of the results of compliance checks, and warnings of enforcement by police or health officials. Out of 11 studies that assessed the effects of an intervention on illegal sales, measured by compliance checks, six found that interventions reduced the sale of illegal sales compared to control sales. Active enforcement was used in three of the successful interventions. Four out of 11 studies that assessed self-reported actual or perceived ease of access found a decrease in test sales. In addition, four of seven trials where smoking prevalence compared against a control area found some evidence of an effect of intervention on youth smoking behaviour. Successful interventions used a variety of strategies, including personal visits and mobilising community support. In addition, enforcement, or warnings of enforcement, had some effect on retailer behaviour but sustaining compliance required regular enforcement (e.g. 4-6 times a year). The authors note that enforcement may produce a backlash against tobacco control activities if the value of reducing sales has not been adequately publicised.
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Table 16. Quality assessment for systematic reviews included in the evidence review

Author(s)	Were inclusion/exclusion criteria reported that addressed the review question?*	Was the search adequate?*	Was the validity of the included studies assessed?	Are sufficient details about the individual included studies presented?
Bruce & van Teijlingen 1999	✓	✓	x	✓
Christakis et al 2003	✓	✓	x	✓
Dennis & Kingston 2008	✓	✓	✓	✓
Fletcher et al 2008	✓	✓	✓	✓
Garrison et al 2003	✓	✓	✓	✓
Gehrman & Hovell 2003	✓	✓	x	✓
Grinshaw & Stanton 2006	✓	✓	✓	✓
Hopkins et al 2001	✓	✓	✓	✓
Kavanagh et al 2006	✓	✓	✓	✓
Levitt et al 2007	✓	✓	✓	✓
Lumley et al 2004	✓	✓	✓	✓
Müller-Riemenschneider et al 2008	✓	✓	✓	✓
Naughton et al 2008	✓	✓	✓	✓
Petrie et al 2007	✓	✓	✓	✓
Priest et al 2008	✓	✓	✓	✓
Sowden & Stead 2003	✓	✓	✓	✓
Sowden 1998	✓	✓	✓	✓
Stead & Lancaster 2005	✓	✓	✓	✓
Sussman et al 2006	✓	✓	x	x
Thomas & Perera 2006	✓	✓	✓	✓
Thomas et al 2007	✓	✓	✓	✓
Thomson et al 2006	✓	✓	x	✓
Wiehe et al 2005	✓	✓	x	✓

*Mandatory criteria

Appendix H. List of local youth councils in the North West

- All Saints Youth Council (Kirkby)
- Barrow and District Youth Council
- Blackpool Voice <http://www.rubothered.co.uk/>
- Blackpool Youth People's Council
- Cheshire County Youth Council
- Congleton Borough Youth Forum
- Crosby Youth Council
- Dingle Youth Forum
- Formby Youth Council
- Fylde Youth Council
- Halewood Youth Town Council www.halewoodtowncouncil.gov.uk/Youth_Council.aspx
- Horncastle Youth Council
- Lancashire Youth Parliament
- Liverpool Youth Service
- Lytham St Anne's Youth Council
- Maghull and District Youth Council
- Millennium Volunteers North West Youth Forum (Parr, St Helens)
- Milnrow and Newhey Youth Forum
- Oldham Council for Voluntary Youth Services
- Oldham Youth Council (OCVYS)
- Ribble Valley Borough Youth Council
- South Lakeland Youth Council
- South Lakes Youth Council
- South Ribble Youth Council
- St Helens Youth Forum
- Stockport Youth Affairs Forum
- Voluntary Youth Network www.lcvys.org.uk/members/VYNET.htm
- Wharton Youth Parish Council
- Wigan Youth Councils
- Worcester Road Youth Council (Bootle)
- Youth Issues Network Youth Council (Ellesmere Port)