

NHS Health Scotland Commentary on NICE Public Health Intervention Guidance	
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Signed off by:	Andrew Tannahill Head of Evidence for Action, NHS Health Scotland
Date signed off:	5 February 2009

NICE ref:	Public health guidance 14 (PH014)
HS ref:	NICEPHG014
Title:	Mass-media and point-of-sales measures to prevent the uptake of smoking by children and young people
Date issued:	July 2008

Subject area:	Tobacco; Children & young people
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Background to this Commentary

The National Institute for Health and Clinical Excellence (NICE) in England produces two types of guidance on public health topics: Public Health Intervention Guidance (interventions being defined as involving single measures, eg GP advice to patients to be more active) and Public Health Programme Guidance (on broader activities, eg strategies for smoking cessation). In Scotland, such Guidance has no formal status but attracts interest and provides a useful source of reviewed evidence.

As part of its role in promoting and supporting evidence-informed action for health improvement in Scotland, NHS Health Scotland (HS) produces Commentaries on NICE Public Health Guidance. Each Commentary, with Comments/Conclusions on the Recommendations set out in the NICE Guidance, is produced in collaboration with an appropriately constituted specialist Reference Group with members from within and beyond HS. The process involves consideration of the evidence cited and the Recommendations presented in the NICE Guidance, in the context of policy and practice in Scotland.

Purpose and limitations of this Commentary

By offering Comments/Conclusions on NICE Guidance, this Commentary is intended to help organisations, professionals and others make use of that Guidance in a Scottish context. It does not in itself constitute formal Guidance or Guidelines.

The scope and contents of the Commentary are limited by those of the NICE Guidance on which it is based. The Commentary should not be seen as a full action plan or full basis for a health improvement strategy on the subject area concerned, but rather as one evidence-informed contribution to such an action plan or strategy. By not only addressing the NICE Recommendations but also presenting in an accessible way the cited evidence statements on which these are based, the Commentary gives decision makers the opportunity to formulate their own action points informed by the evidence statements, combining these with evidence from other sources and taking account of other relevant considerations.

The Commentary

General HS Notes:

- 1. NICE Public Health Guidance 14 (NICEPHG014) is intended for all those with a remit to improve the health and wellbeing of children and young people under 18, including those working in the NHS, local authorities, the criminal justice system and the wider public, voluntary and community sectors. It is also aimed at the private sector, in particular the retail industry and mass media services. In addition, it is considered to be of possible interest to children, young people and their carers, as well as other members of the public.*
- 2. NICE is also working on Guidance specifically for Local Authorities and NHS primary care services on school-based interventions to prevent the uptake of smoking among children. HS intends to produce a Commentary on that Guidance when it is published.*
- 3. In developing the Recommendations set out in NICEPHG014, NICE's Public Health Interventions Advisory Committee (PHIAC) considered a review of evidence of effectiveness, qualitative and quantitative research with children and young people, an economic appraisal (comprising a review of economic evaluations and a cost effectiveness analysis), stakeholder comments, and the results of fieldwork. In this Commentary, the evidence statements cited for each of the NICEPHG014 Recommendations for action are presented immediately under the corresponding Recommendations, for ease of reference.*

General HS Notes, contd:

4. NICEPHG014 states that:

- children who smoke become addicted to nicotine very quickly and tend to continue the habit into adulthood.
- around two-thirds of people who have smoked took up the habit before the age of 18
- because the risk of disease is related to the length of time a person has smoked, people who take up smoking before the age of 18 face a greater-than-average risk of developing lung cancer or heart disease
- children and young people who smoke are 2–6 times more susceptible than their non-smoking peers to coughs, increased phlegm and wheezing; smoking can impair the growth of their lungs, and is a cause of asthma-related symptoms in childhood and adolescence.

5. NICEPHG014 indicates:

- that mass-media and point-of-sales measures should be combined with other prevention activities as part of a comprehensive tobacco control strategy; that such a strategy is defined by the World Health Organization and others as encompassing price and regulation policies, education programmes, cessation support services and community programmes; and that the strategy should be sufficiently extensive and sustained to have a reasonable chance of success
- that there was a paucity of evidence on how socioeconomic status and other measures of inequality might affect children and young people's response to mass-media interventions discouraging tobacco use or the effectiveness of tobacco access restrictions; and that, when implementing the Recommendations, careful consideration should be given to the potential impact on health inequalities.

6. Scottish contextual points –

- This Commentary should be read together with the following key Scottish policy and strategy documents:
 - Scotland's Future is Smoke Free: A Smoking Prevention Action Plan (*The Scottish Government, 2008*) – which set out a programme designed to dissuade children and young people from smoking that includes mass media and points-of-sale measures (see www.scotland.gov.uk/Resource/Doc/223415/0060163.pdf)
 - A Breath of Fresh Air for Scotland – Improving Scotland's Health: The Challenge – Tobacco Control Action Plan (*Scottish Executive, 2004*) – the first ever action plan on tobacco control designed specifically for Scotland, which among other things referred to 'development of a coherent, integrated long-term communications strategy to guide future prevention activity at national and local levels', and to measures against illegal sales (see www.scotland.gov.uk/Resource/Doc/26487/0013536.pdf)

General HS Notes, contd:

- Better Health, Better Care: Action Plan (*The Scottish Government, 2007*) www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf – which among other things: highlighted the importance of smoking as 'still the biggest cause of premature death in Scotland, especially in disadvantaged communities'; referred to the increasing of the minimum age for purchasing tobacco from 16 to 18 years; and expressed commitment to develop the above Smoking Prevention Action Plan
- Equally Well: Report of the Ministerial Task Force on Health Inequalities (*The Scottish Government, 2008*) – recommendation 51 in which stated: 'It should be a key priority within the Government's smoking strategy that NHS Boards and their local partners act to prevent young people in deprived communities from smoking, and to provide more effective support to smokers in those communities to quit' (see www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf)
- Equally Well Implementation Plan (*The Scottish Government, 2008*) – which set out actions on Equally Well recommendation 51, including implementation of the Smoking Prevention Action Plan and launch of the Enhanced Tobacco Sales Enforcement Programme (which identifies new targets for an outcomes-focused scheme to secure more rigorous enforcement of tobacco sales law); it also placed social marketing addressing smoking in the wider context of *The Scottish Government's Health Improvement Social Marketing Strategy* (within which discouraging children and young people from smoking is an important focus); see www.scotland.gov.uk/Resource/Doc/254248/0075274.pdf.
- Scotland's Future is Smoke Free: A Smoking Prevention Action Plan set out targets to reduce the level of smoking amongst:
 - 13 year-old girls from 5% in 2006 to 3% in 2014; 13 year-old boys from 3% in 2006 to 2% in 2014
 - 15 year-old girls from 18% in 2006 to 14% in 2014; 15 year-old boys from 12% in 2006 to 9% in 2014
 - 16 to 24 year-olds from 26.5% in 2006 to 22.9% in 2012.
- Other specific Scottish contextual considerations are highlighted where relevant in this Commentary.

<p>Scope of the Guidance:</p>	<p><u>Focus</u></p> <ul style="list-style-type: none"> ▪ Preventing the uptake of cigarette smoking. <p><u>Groups covered</u></p> <ul style="list-style-type: none"> ▪ All children and young people under the age of 18. <p><u>Areas covered</u></p> <ul style="list-style-type: none"> ▪ Mass media interventions: programmes or campaigns aimed at reaching large numbers of people via television, radio, new media (including web and text messaging), newspapers, bill boards, posters, leaflets, or booklets. ▪ Point-of-sale measures: this may include educating retailers and the general public about the law, proof of age schemes, regulation and law enforcement (including encouraging members of the community to help enforce the law). <p><u>Areas not covered</u></p> <ul style="list-style-type: none"> ▪ Preventive interventions such as: <ul style="list-style-type: none"> - family, education and social interventions which inform family members and peers who smoke about the influence they exert on children and young people's choices about tobacco - community-based interventions: coordinated programmes aimed at a particular geographical area or region, or groups of people who share common needs or interests, to prevent the uptake of smoking - school-based interventions: classroom programmes or curricula to deter tobacco use, including those associated with family and community interventions. ▪ Increasing the price of tobacco products. ▪ Interventions to encourage and support children and young people to quit smoking. ▪ Interventions to discourage or reduce the uptake of tobacco chewing and the use of smokeless tobacco. <p><u>Outcomes</u></p> <ul style="list-style-type: none"> ▪ Primary outcome measures for children and young people were to include: <ul style="list-style-type: none"> - smoking rates among this group - reports from children and young people on how they obtain their cigarettes - self-reported smoking behaviour - objective measures of smoking behaviour.
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<p>Scope of the Guidance, contd:</p>	<ul style="list-style-type: none"> ▪ Secondary outcome measures for children and young people were to include: <ul style="list-style-type: none"> – children and young people’s knowledge about – and attitudes towards – smoking (including intention to smoke) – children and young people’s decision-making, refusal skills and self-esteem. ▪ Primary outcome measures for professionals responsible for preventing illegal tobacco sales were to include: <ul style="list-style-type: none"> – number of warnings and cautions issued – number of spot checks – number of local authorities using children in test purchasing exercises – number of criminal proceedings and successful prosecutions. <p><u>Overriding questions</u></p> <ul style="list-style-type: none"> ▪ Which mass media interventions are effective and cost effective in preventing children and young people from becoming smokers? ▪ Which interventions are effective and cost effective in reducing the illegal sale of tobacco to children and young people? ▪ When appropriate interventions can be compared, which are most effective in preventing the uptake of smoking and the sale of tobacco to children and young people? ▪ Are the interventions delaying rather than preventing the onset of smoking? ▪ How would differences between the comparators used in published studies and the prevailing situation in England impact on the analysis of effectiveness and cost effectiveness? <p>It was noted that not all of the questions would apply to all of the interventions.</p>
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<p>Scope of the Guidance, contd:</p>	<p><u>Subsidiary questions</u></p> <ul style="list-style-type: none"> ▪ How does the way that the intervention is delivered influence effectiveness? ▪ Does effectiveness depend on the status of the person delivering it (eg retailer, trading standards officer, magistrate)? ▪ Does the site/setting influence effectiveness? ▪ Does the intensity of the intervention influence effectiveness or duration of effect? ▪ How does effectiveness vary according to the age, sex, socioeconomic status or ethnicity of the target audience? ▪ How much does the intervention cost, in terms of money, people and time? ▪ What evidence is there on cost effectiveness? ▪ What are the facilitators and barriers to implementation? <p>It was noted that not all of the questions would apply to all of the interventions.</p> <p><u>Target audiences and settings</u></p> <ul style="list-style-type: none"> ▪ Those directly and indirectly responsible for the health and care of children under 18, including parents, foster carers, local authority children’s services, children’s charities, child and adolescent mental health services, schools, pupil referral units and further education colleges, youth services and youth offending institutions. ▪ Professionals with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. ▪ Those who sell and promote tobacco products (including product placement and use of role models). ▪ Those responsible for monitoring and enforcing legislation (eg local authority, trading standards) on the sale of tobacco to those aged under 18.
<p>HS Comments on scope:</p> <p>1. <i>Supported in the specific context of the Guidance.</i></p>	

<p>Study selection criteria etc:</p>	<p><u>Effectiveness review</u> – 'Interventions to prevent the uptake of smoking in children and young people'</p> <p>A number of databases were searched for relevant systematic reviews, experimental studies and qualitative studies (1996–2006), and a number of websites were searched for relevant reports.</p> <p>Studies were <u>included</u> if they:</p> <ul style="list-style-type: none"> ▪ focused on children and young people aged under 18 ▪ used mass-media communications, including new media (such as podcasting, text messaging or social networking websites) to prevent the uptake of smoking ▪ aimed to prevent sales of tobacco to children and young people ▪ were published in English from 1990 onwards. <p>Studies were <u>excluded</u> if they:</p> <ul style="list-style-type: none"> ▪ focused on those aged 18 and over ▪ focused on family, education or social interventions ▪ were school-based ▪ included counselling or self-help and did not involve the use of mass media ▪ focused on price measures ▪ were conducted in a developing country or not published in English. <p>Further details of the search strategy can be found in the review report, at www.nice.org.uk/PH014 ('Documents' – 'Background information').</p> <p><u>Review of economic evaluations</u></p> <p>A number of databases were searched for studies published since 1990.</p> <p>Studies were eligible for <u>inclusion</u> if:</p> <ul style="list-style-type: none"> ▪ they included children and young people aged up to 18 ▪ the population covered did not smoke at the start of the study ▪ they reported on the cost and effectiveness of the prevention strategy.
<p><i>HS Comments on study selection criteria etc:</i></p> <p>1. <i>Supported for the purpose in question.</i></p>	

<p>Study appraisal methods etc:</p>	<p><u>Effectiveness review</u> Included evidence sources were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the relevant NICE technical manual.</p> <p>Each evidence source was categorised as one of four <u>types</u>:</p> <ul style="list-style-type: none"> ▪ Meta-analyses, systematic reviews of randomised controlled trials (RCTs) or RCTs (including cluster RCTs). ▪ Systematic reviews of, or individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies. ▪ Non-analytical studies (eg case reports, case series). ▪ Expert opinion, formal consensus. <p>Each study was quality rated (++, + or -) according to the risk of potential bias arising from its design and execution/other criteria as appropriate. The interventions were also assessed for their applicability to the UK, and statements on applicability were included in evidence statements.</p> <p>The findings from the review were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements reflect the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.</p> <p><u>Review of economic evaluations</u> The 'Drummond checklist' was used for quality assurance. (See Drummond MF, Jefferson TO. Guidelines for authors and peer reviewers of economic submissions to the BMJ. <i>BMJ</i> 2006;313:275–83.)</p> <p><u>Qualitative research: focus groups</u> A range of qualitative and quantitative research methods were used. The sample comprised: young people in school and sixth form colleges; a group of young people who were at risk of exclusion, or had been excluded from, mainstream education; and a group of young people in contact with smoking cessation services. Full details of the methodology, data analysis and ethical approval for the project can be found in the focus group report, available at www.nice.org.uk/PH014 ('Documents' – 'Background information').</p>
<p>HS Comments on study appraisal methods etc:</p> <p>1. <i>Supported.</i></p>	

NICEPHG014 Recommendations for action, and HS Comments/Conclusions

HS Notes:

1. The 5 Recommendations for action in NICEPHG014 are presented under 2 headings: 'Mass media' and 'Illegal sales'. The 3 'Mass media' Recommendations respectively relate to the following themes: campaign development; campaign messages; and campaign strategies.
2. The evidence statements cited in support of the action Recommendations in NICEPHG014 are numbered here as they are in the Guidance, for ease of comparison between Recommendations and cross-reference between this Commentary and the Guidance. Those from the effectiveness review are numbered 1, 1.1, 1.1.1 etc, and those from the focus group research report FG1–FG9.

A. Mass media

Recommendation 1 (campaign development):

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.

<p>Evidence base for Recommendation 1 (campaign development):</p>	<ol style="list-style-type: none"> 1. <u>Evidence statement 1</u> There is evidence that mass-media campaigns can prevent the uptake of smoking and also influence knowledge, attitudes and intentions of children and young people. Factors that have been shown to influence effectiveness in terms of attitudes, perceptions, beliefs and intentions include message source, message content, message format, message framing, duration, target audience, demographics of the audience, and the site/setting of the campaign. Factors that have been shown to influence effectiveness in terms of smoking behaviour (ie smoking in the past 30 days, decreased initiation of smoking, quitting, number of cigarettes smoked) include message content, target audience, duration of the mass-media campaign, demographics of the audience, the number of anti-tobacco message sources and the Truth campaign. Overall, the factors outlined above work best when combined with broader tobacco control initiatives produced by tobacco control bodies. Furthermore, campaigns are most effective when they are long in duration and greater in intensity of exposure. 2. <u>Evidence statement 1.1</u> Some mass-media interventions are more effective than others. Comparing interventions, prevention campaigns produced by the tobacco industry are less effective than anti-tobacco campaigns produced by tobacco control bodies. Young people perceive industry campaigns to be less effective, less interesting and less engaging. Industry campaigns also 'appeared to move youth attitudes in a pro-tobacco direction'. 3. <u>Evidence statement 1.1.1</u> Evidence from one cluster RCT (++) suggesting that adolescents perceive tobacco industry sponsored advertisements less favourably and as less effective (ie, participants rated these advertisements as less convincing and less helpful in keeping friends from smoking and starting smoking) in reducing smoking (specifically, fewer people taking up smoking based on the following outcome measures: intention to smoke, curiosity of tobacco use, tobacco industry sympathy) than other smoking prevention advertisements, but also express greater sympathy with the tobacco companies after viewing their advertisements. Yet, neither the industry sponsored nor other prevention advertisements changed adolescent's intention to smoke. One cross-sectional (+) study found that an American tobacco control campaign did increase anti-tobacco attitudes and beliefs, while an industry-sponsored campaign 'appeared to move youth attitudes in a pro-tobacco direction'. Similarly, one cross-sectional study (++) found that exposure to tobacco industry youth-targeted smoking prevention advertising generally had no beneficial outcomes (measured by young people's attitudes, beliefs and intentions regarding the tobacco industry, and tobacco
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<p>Evidence base for Recommendation 1 (campaign development), contd:</p>	<p>use 10 months into the Truth campaign). Exposure to tobacco company parent-targeted advertising was associated with lower perceived harm of smoking, stronger approval of smoking, stronger intentions to smoke in the future and greater likelihood of having smoked in the past 30 days. Another (+) US-based cross-sectional study found that tobacco industry advertisements were less interesting, less cognitively engaging, and held less negative emotional appeal for teenagers than advertisements created by tobacco control programmes.</p> <p>4. <u>Evidence statement 1.3.1</u> How an intervention is delivered does influence the attitudes, perceptions and behaviours of young people. Evidence from two (+) reviews found that message content does influence the effectiveness of an intervention (see below), though the impact is not consistent, and also depends on the duration of delivery. One (++) RCT study found that message content could change perceptions of health risk severity and intentions not to smoke, though none of the message themes resulted in: increased self-efficacy for refusing cigarette offers or resisting tobacco marketing, or improved health risk vulnerability. Another (++) RCT study found that using tobacco-related disease messaging was more effective for increasing anti-tobacco attitudes and perceptions of social disapproval risks associated with smoking, whereas anti-industry advertisements did not decrease young people's intention to smoke. Evidence from a US cross-sectional (+) study found that 'truth' messages were effective in decreasing and preventing smoking in young people (Florida teens were less likely to smoke in the past 30 days, to have ever tried smoking, or to indicate that they could not rule out the possibility of smoking in the future). A UK-based (++) qualitative study found that social norms messages were more effective than fear messages at encouraging more committed smokers to consider their smoking behaviours and reinforcing awareness of the dangers of smoking in less committed smokers. 'Industry manipulation advertisements' were aesthetically appealing but ineffective for preventing the uptake of smoking. Similarly, one (+) review and one RCT (+) study concludes that anti-smoking advertisements can improve smoking prevention and cessation in the young (by making them less likely to smoke, have lower intentions to smoke, and have greater intentions to quit smoking), but the specific outcomes of any message type depends on the context and the values that the audience associates with smoking.</p> <p><u>Applicability:</u> most of the studies were conducted in the USA. It is not clear if these findings are directly applicable to the</p>
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<p>Evidence base for Recommendation 1 (campaign development), contd:</p>	<p>UK since the mass-media campaigns under investigation are specific to the USA. Furthermore, demographics of participants are different from those in the UK. International review data may be broadly applicable to the UK since the review is international in scope.</p> <p>5. <u>Evidence statement 1.3.3</u> Evidence from one cross-sectional (+) study and one (+) review suggest that adult-focused or general population campaigns are successful in reducing smoking (cutting down the number of cigarettes smoked, increasing the numbers attempting to quit, making it easier to stay a non-smoker) in young people. Yet, one (+) review contends that both messages aimed at young people and general messages can be effective in developing awareness, and changing attitudes and behaviours associated with tobacco use, as long as messages are not deemed patronising by the young. <u>Applicability:</u> no studies were conducted in the UK. It is not clear if the findings are directly relevant to the UK.</p> <p>6. <u>Evidence statement 1.3.4</u> One RCT (+) found that message framing impacts the effectiveness of an intervention by lowering intentions to smoke, lowering the perceived pharmacological benefits of smoking, and lowering the perceived psychological benefits of smoking. In particular, it is important that the message framing is consistent with the desired outcome. <u>Applicability:</u> given the broad cultural differences between South Korea and the UK, the findings of this study are less relevant to the UK.</p> <p>7. <u>Evidence statement 1.4.1</u> No studies specifically discussed how the status of a person delivering an intervention can have an impact on its effectiveness. Yet, one cross-sectional study (+) and one (+) review reveal that young people who are exposed to a large variety of anti-tobacco sources are more likely to refuse tobacco, and that social interactions can support anti-tobacco messaging. Evidence from two cross-sectional studies (+) indicates that the tobacco industry is not a trusted source of anti-tobacco information among young people. <u>Applicability:</u> it is not clear if the findings are directly applicable to the UK as they are USA-based. However, international review data may be broadly applicable, since multiple studies have produced similar results. Given the differences in demographics of study participants and the interventions under investigation it is not clear if findings are directly applicable to the UK.</p>
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<p>Evidence base for Recommendation 1 (campaign development), contd:</p>	<p>8. <u>Evidence statement 1.7</u> Effectiveness may vary according to a variety of demographic factors. Mass-media campaigns appear to benefit younger children more than their older counterparts. However, findings regarding the impact of sex and ethnicity are inconclusive. Mass-media messages and themes are received differently depending on age, sex, and ethnicity. There was a lack of information regarding the impact of socioeconomic status. A variety of other individual characteristics can also impact effectiveness. In particular:</p> <p>9. <u>Evidence statement 1.7.1</u> Several studies discuss sex and gender-based differences in the effectiveness of media interventions. One RCT (+) found that for girls, cosmetic advertisements had a greater impact on smoking behaviour (including how often they smoked, how long they have been smoking for and the number of cigarettes smoked) and intentions to quit; while health ads had a greater impact on the smoking behaviour of boys (including how often they smoked, how long they have been smoking for and the number of cigarettes smoked) and intentions to quit. Health advertisements were also most useful for reducing girls' and boys' intention to start smoking. Evidence from one (+) cohort study found that over time, boys were more susceptible (expressed greater interest in smoking uptake) to smoking than girls. One (3 +) cross-sectional study found no gender differences in the effectiveness of an anti-smoking campaign. A cross-sectional (-) study found that while awareness was similar for girls and boys, girls had a greater recall of anti-tobacco messaging. In a (+) cross-sectional study based in Norway, girls demonstrated a stronger behavioural response (reporting that the campaign had affected their beliefs or decisions concerning smoking) to an anti-smoking media campaign that was targeted at girls. <u>Applicability:</u> none of these studies was conducted in the UK. It is not clear if the findings are directly relevant, as gender is culturally defined and prescribed.</p> <p>10. <u>Evidence statement 1.7.2</u> Evidence from one review (+), one US-based cohort study (+), and four cross-sectional (two [++], one [+], and one [-]) studies reveals that for younger children, media campaigns are more likely to decrease intentions to smoke and improve smoking behaviour by decreasing initiation rates and continuation of current smoking. Similarly, one review (+) suggests that those close to the minimum legal age (older youth) are less affected by anti-tobacco industry campaigns since they have the least awareness of, and receptivity to, mass-media messages. In order to target this group, they suggest using campaigns that appeal to the general population, rather than just young people. Conversely, one cross-sectional study (+) found that older youth demonstrated greater change in behavioural intentions after exposure to a media campaign. Also, one</p>
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<p>Evidence base for Recommendation 1 (campaign development), contd:</p>	<p>cross-sectional (+) study testing emotional reactions to smoking advertisements, found only a weak relationship between age and response. Evidence from one RCT study (+) found that message content differentially impacts the outcomes of the campaign (how often young people smoke, number of cigarettes smoked, intentions to start smoking, and intentions to quit), depending on the age of the students. In general, health messages were more effective in changing smoking behaviour (how often young people smoke, how long they have been smoking, and the number of cigarettes smoked), intention to start smoking and intention to quit smoking for older students. Cosmetic messages were more effective in changing smoking behaviour (how often young people smoke and the number of cigarettes smoked) for younger students. In another RCT (+) study, the investigators also concluded that age and message types have a statistically significant impact on the interpretation of tobacco-related messages. Older youth were less likely to positively accept explicit anti- or pro-tobacco messages that limited their internalised decision making, compared to younger children.</p> <p><u>Applicability:</u> none of these studies was conducted in the UK. It is not clear if findings are directly relevant.</p> <p>11. <u>Evidence statement 1.7.3</u> A variety of studies explored the impact of ethnicity on the effectiveness of youth interventions. One (++) cross-sectional study revealed that African Americans and Hispanics were more affected (defined as the level to which young people reported advertising had made them less likely to smoke cigarettes) by anti-smoking messaging than white young people. Evidence from one cross-sectional (+) study found no relationship between ethnicity and emotional reaction to anti-smoking messages. Finally, one (+) cross-sectional study found that a web-based tobacco prevention programme had a greater impact on intentions not to smoke among Hispanic and white students than black students.</p> <p><u>Applicability:</u> as these studies deal with specific populations in the USA, it is unclear how applicable these findings are to a UK setting.</p> <p>12. <u>Evidence statement 1.7.4</u> One cross-sectional (+) study found that a number of variables were associated with a greater intention to smoke, including: brand recognition, willingness to use or wear products with tobacco brands, stress and having friends who smoke. Having a live-in father who smoked, and agreeing with anti-tobacco ads were both associated with a lesser intention to smoke. Evidence from one cross-sectional (+) study found that young people who smoked demonstrated a greater awareness of the pervasiveness of anti-smoking campaigns than among</p>
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<p>Evidence base for Recommendation 1 (campaign development), contd:</p>	<p>young people who had never smoked or who were susceptible to smoking. <u>Applicability:</u> as neither of the studies was conducted in the UK it is not clear if findings are directly relevant.</p> <p>13. <u>Evidence statement FG2</u> There was evidence to suggest that national smoking prevention campaigns with both adult and young person-oriented messages would be successful approaches for reducing smoking.</p>
<p>HS Comments/Conclusions on Recommendation 1 (campaign development):</p> <p>1 Supported subject to adaptation to fit Scottish scale, organisational arrangements/responsibilities and professional roles, and addition of the following sub-point under the first main bulleted action point (The campaigns should:):</p> <ul style="list-style-type: none"> - be set within longer-term communication strategies, and wider smoking prevention and tobacco control strategies. <p>2 Scottish contextual points –</p> <ul style="list-style-type: none"> ▪ One of the action points set out in Scotland's Future is Smoke Free: A Smoking Prevention Action Plan (The Scottish Government, 2008) was: 'To ensure as part of the youth strand of the HISMS [Health Improvement Social Marketing Strategy – see page 4 of this Commentary] an ongoing multi-stranded media campaign is in place to discourage uptake of smoking by young people'. Another action point was 'To consider, as part of the collaborative planning and approval mechanisms under the HISMS, the value of developing a multi-faceted campaign, integrated with local services and initiatives and engaging the full range of health and other professionals, which is targeted at parents to raise awareness of the impact of tobacco on their children's health, including for second-hand smoke, specifically aimed at encouraging smoke-free lifestyles, homes and family vehicles. (See www.scotland.gov.uk/Publications/2008/05/19144342/13.) ▪ Existing sub-national infrastructure in Scotland relevant to tobacco prevention activities includes local tobacco control alliances (see www.ashscotland.org.uk/ash/5144.781.781.html), and youth/tobacco-related posts in some NHS Boards. 	

<p>Recommendation 2 (campaign messages):</p>	<p><u>Target population</u></p> <ul style="list-style-type: none"> ▪ Children and young people under 18. <p><u>Who should take action?</u></p> <ul style="list-style-type: none"> ▪ 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. <p><u>What action should they take?</u></p> <ul style="list-style-type: none"> ▪ Convey messages based on strategic research and qualitative pre- and post-testing with the target audiences. These could include messages that: <ul style="list-style-type: none"> - elicit a strong, negative emotional reaction (eg 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 (eg its effect on the appearance of skin and teeth). ▪ Repeat the messages in a number of ways and regularly update them to keep the audience's attention.
<p>Evidence base for Recommendation 2 (campaign messages):</p>	<p>1. <u>Evidence statement 1</u> There is evidence that mass-media campaigns can prevent the uptake of smoking and also influence knowledge, attitudes and intentions of children and young people. Factors that have been shown to influence effectiveness in terms of attitudes, perceptions, beliefs and intentions include message source, message content, message format, message framing, duration, target audience, demographics of the audience, and the site/setting of the campaign. Factors that have been shown to influence effectiveness in terms of smoking behaviour (ie smoking in the past 30 days, decreased initiation of smoking, quitting, number of cigarettes smoked) include message content, target audience, duration of the mass-media campaign, demographics of the audience, the number of anti-tobacco message sources and the Truth campaign. Overall, the</p>

<p>Evidence base for Recommendation 2 (campaign messages), contd:</p>	<p>factors outlined above work best when combined with broader tobacco control initiatives produced by tobacco control bodies. Furthermore, campaigns are most effective when they are long in duration and greater in intensity of exposure.</p> <p>2. <u>Evidence statement 1.3.1</u> How an intervention is delivered does influence the attitudes, perceptions and behaviours of young people. Evidence from two (+) reviews found that message content does influence the effectiveness of an intervention (see below), though the impact is not consistent, and also depends on the duration of delivery. One (++) RCT study found that message content could change perceptions of health risk severity and intentions not to smoke, though none of the message themes resulted in: increased self-efficacy for refusing cigarette offers or resisting tobacco marketing, or improved health risk vulnerability. Another (++) RCT study found that using tobacco-related disease messaging was more effective for increasing attitudes and perceptions of social disapproval risks associated with smoking, whereas anti-industry advertisements did not decrease young people's intention to smoke. Evidence from a US cross-sectional (+) study found that 'truth' messages were effective in decreasing and preventing smoking in young people (Florida teens were less likely to smoke in the past 30 days, to have ever tried smoking, or to indicate that they could not rule out the possibility of smoking in the future). A UK-based (++) qualitative study found that social norms messages were more effective than fear messages at encouraging more committed smokers to consider their smoking behaviours and reinforcing awareness of the dangers of smoking in less committed smokers. 'Industry manipulation advertisements' were aesthetically appealing but ineffective for preventing the uptake of smoking. Similarly, one (+) review and one RCT (+) study concludes that anti-smoking advertisements can improve smoking prevention and cessation in the young (by making them less likely to smoke, have lower intentions to smoke, and have greater intentions to quit smoking), but the specific outcomes of any message type depends on the context and the values that the audience associates with smoking.</p> <p><u>Applicability:</u> most of the studies were conducted in the USA. It is not clear if these findings are directly applicable to the UK since the mass-media campaigns under investigation are specific to the USA. Furthermore, demographics of participants are different from those in the UK. International review data may be broadly applicable to the UK since the review is international in scope.</p>
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<p>Evidence base for Recommendation 2 (campaign messages), contd:</p>	<p>3. <u>Evidence statement 1.3.3</u> Evidence from one cross-sectional (+) study and one (+) review suggest that adult-focused or general population campaigns are successful in reducing smoking (cutting down the number of cigarettes smoked, increasing the numbers attempting to quit, making it easier to stay a non-smoker) in young people. Yet, one (+) review contends that both messages aimed at young people and general messages can be effective in developing awareness, and changing attitudes and behaviours associated with tobacco use, as long as messages are not deemed patronising by the young. <u>Applicability:</u> no studies were conducted in the UK. It is not clear if the findings are directly relevant to the UK.</p> <p>4. <u>Evidence statement 1.3.4</u> One RCT (+) found that message framing impacts the effectiveness of an intervention by lowering intentions to smoke, lowering the perceived pharmacological benefits of smoking, and lowering the perceived psychological benefits of smoking. In particular, it is important that the message framing is consistent with the desired outcome. <u>Applicability:</u> given the broad cultural differences between South Korea and the UK, the findings of this study are less relevant to the UK.</p> <p>5. <u>Evidence statement 1.3.5</u> One (+) review contends that effective messaging should attend to all elements (such as content, format and tone). Specifically, evidence from one cross-sectional (+) study suggests that message processing in older teens improves when messages incorporate unrelated cuts and use suspenseful images. One cross-sectional study (+) found sources were evaluated more positively for implicit rather than explicit messages, and for anti-smoking rather than pro-smoking messages. Evidence from an RCT (++) study reveals that exposure to cigarette advertisements depicting young people can decrease negative stereotypic beliefs about smoking and increase an intention to smoke in the young. <u>Applicability:</u> the demographics of study participants and the mass-media interventions under investigation are specific to the USA. It is not clear if findings are applicable to the UK.</p> <p>6. <u>Evidence statement 1.6.1</u> Evidence from one (++) Cochrane review suggests that the duration of an intervention will have the greatest bearing on health behaviours. In support of this, evidence from three cross-sectional studies (one [++] and two [+]) identified by the literature search, reveals that increased exposure to anti-smoking advertisements over time results in a decrease in: young people smoking in the past 30 days (compared to those in markets with no exposure to state-sponsored anti-tobacco laws), intent to smoke, initiation of smoking, enhanced perception of risk, and negative attitudes about smoking. Similarly, two cross-</p>
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<p>Evidence base for Recommendation 2 (campaign messages), contd:</p>	<p>sectional (+) US studies demonstrate that young people living in states with aggressive counter-industry media campaigns are more likely to have 'negative beliefs about tobacco industry practices', are less likely to smoke, and are more informed about the dangers of second-hand smoke. As well, one (+) cohort study found that pro-tobacco media increased susceptibility to smoking, while anti-tobacco media decreased susceptibility. Conversely, one (++) US-based cross-sectional study did not find a relationship between exposure to anti-smoking campaigns and improved ideas about smoking or health behaviours. They argue that in order to be effective, exposure must be supported by other tobacco control initiatives. A cross-sectional (++) study found increased exposure to anti-tobacco mass-media messages in the absence of school-based tobacco prevention measures was not successful in reducing tobacco use among adolescents.</p> <p><u>Applicability:</u> none of the studies was conducted in the UK. However, given the nature of exposure to mass-media campaigns, findings may be applicable to the UK.</p> <p>7. <u>Evidence statement 1.6.2</u> Results from four cross-sectional studies (two [++] and two [+]) indicate that the Truth campaign was successful in improving the prevention of youth smoking over time. Studies show that the campaign resulted in: decreased prevalence rates of smoking in young people (through reduced uptake and/or increased quitting), greater agreement with anti-smoking statements by young people, and stronger anti-tobacco attitudes and beliefs.</p> <p><u>Applicability:</u> The Truth campaign is a USA anti-tobacco mass-media campaign. Due to the nature of the campaign and the demographics of US young people, results are not directly relevant to the UK.</p> <p>8. <u>Evidence statement 1.7</u> Effectiveness may vary according to a variety of demographic factors. Mass-media campaigns appear to benefit younger children more than their older counterparts. However, findings regarding the impact of sex and ethnicity are inconclusive. Mass-media messages and themes are received differently depending on age, sex, and ethnicity. There was a lack of information regarding the impact of socioeconomic status. A variety of other individual characteristics can also impact effectiveness.</p> <p>9. <u>Evidence statement 1.7.1</u> Several studies discuss sex and gender-based differences in the effectiveness of media interventions. One RCT (+) found that for girls, cosmetic advertisements had a greater impact on smoking behaviour (including how often they smoked, how long they have been smoking for and the number of cigarettes smoked) and intentions to quit; while health ads had a greater impact on the smoking behaviour of boys (including how often they smoked, how long they have been smoking for and the</p>
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<p>Evidence base for Recommendation 2 (campaign messages), contd:</p>	<p>number of cigarettes smoked) and intentions to quit. Health advertisements were also most useful for reducing girls' and boys' intention to start smoking. Evidence from one (+) cohort study found that over time, boys were more susceptible (expressed greater interest in smoking uptake) to smoking than girls. One (3 +) cross-sectional study found no gender differences in the effectiveness of an anti-smoking campaign. A cross-sectional (-) study found that while awareness was similar for girls and boys, girls had a greater recall of anti-tobacco messaging. In a (+) cross-sectional study based in Norway, girls demonstrated a stronger behavioural response (reporting that the campaign had affected their beliefs or decisions concerning smoking) to an anti-smoking media campaign that was targeted at girls.</p> <p><u>Applicability:</u> none of these studies was conducted in the UK. It is not clear if the findings are directly relevant, as gender is culturally defined and prescribed.</p> <p>10. <u>Evidence statement 1.7.2</u> Evidence from one review (+), one US-based cohort study (+), and four cross-sectional (two [++], one [+], and one [-]) studies reveals that for younger children, media campaigns are more likely to decrease intentions to smoke and improve smoking behaviour by decreasing initiation rates and continuation of current smoking. Similarly, one review (+) suggests that those close to the minimum legal age (older youth) are less affected by anti-tobacco industry campaigns since they have the least awareness of, and receptivity to, mass-media messages. In order to target this group, they suggest using campaigns that appeal to the general population, rather than just young people. Conversely, one cross-sectional study (+) found that older youth demonstrated greater change in behavioural intentions after exposure to a media campaign. Also, one cross-sectional (+) study testing emotional reactions to smoking advertisements, found only a weak relationship between age and response. Evidence from one RCT study (+) found that message content differentially impacts the outcomes of the campaign (how often young people smoke, number of cigarettes smoked, intentions to start smoking, and intentions to quit), depending on the age of the students. In general, health messages were more effective in changing smoking behaviour (how often young people smoke, how long they have been smoking, and the number of cigarettes smoked), intention to start smoking and intention to quit smoking for older students. Cosmetic messages were more effective in changing smoking behaviour (how often young people smoke and the number of cigarettes smoked) for younger students. In another RCT (+) study, the investigators also concluded that age and message types have a statistically significant impact on the interpretation of tobacco-related messages. Older youth were less likely to</p>
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<p>Evidence base for Recommendation 2 (campaign messages), contd:</p>	<p>positively accept explicit anti- or pro-tobacco messages that limited their internalised decision making, compared to younger children.</p> <p><u>Applicability:</u> none of the studies was conducted in the UK. It is not clear if findings are directly relevant.</p> <p>11. <u>Evidence statement 1.7.3</u> A variety of studies explored the impact of ethnicity on the effectiveness of youth interventions. One (++) cross-sectional study revealed that African Americans and Hispanics were more affected (defined as the level to which young people reported advertising had made them less likely to smoke cigarettes) by anti-smoking messaging than white young people. Evidence from one cross-sectional (+) study found no relationship between ethnicity and emotional reaction to anti-smoking messages. Finally, one (+) cross-sectional study found that a web-based tobacco prevention programme had a greater impact on intentions not to smoke among Hispanic and white students than black students.</p> <p><u>Applicability:</u> as these studies deal with specific populations in the USA, it is unclear how applicable these findings are to a UK setting.</p> <p>12. <u>Evidence statement FG2</u> There was evidence to suggest that national smoking prevention campaigns with both adult and young person-oriented messages would be successful approaches for reducing smoking.</p> <p>13. <u>Evidence statement FG5</u> Despite similar levels of smoking knowledge, current smokers had more positive smoking attitudes, and were less likely to believe that prevention campaigns could be effective. Smoking cessation and prevention campaigns are therefore likely to have differential effects, depending upon current smoking status. Content should be altered depending upon whether the aim of the intervention is to prevent uptake, delay uptake, or promote cessation.</p> <p>14. <u>Evidence statement FG6</u> From the results obtained in this sample, male smokers may be most resistant to attempts to persuade them to change their smoking behaviours.</p> <p>15. <u>Evidence statement FG7</u> If asked to express a preference, young people tend to value 'socially desirable' traditional intervention techniques (ie fear arousal/'shock tactics') rather than evidence-based approaches. Some campaign elements should therefore proceed in opposition to young people's preferences.</p> <p>16. <u>Evidence statement FG8</u> Young people would prefer campaigns to be delivered by well known individuals with personal smoking stories.</p>
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HS Comments/Conclusions on Recommendation 2 (campaign messages):

1. Supported subject to adaptation to fit Scottish scale, organisational arrangements/responsibilities and professional roles.
2. Scottish contextual point – Existing sub-national infrastructure in Scotland relevant to tobacco prevention activities includes local tobacco control alliances (see www.ashscotland.org.uk/ash/5144.781.781.html), and youth/tobacco-related posts in some NHS Boards.

Recommendation 3 (campaign strategies):

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 newsworthy 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.
- Regional and local campaigns should build on, and be integrated with, a national communications strategy to tackle tobacco use. Regional campaigns should use regional press and radio (local campaigns should use local press and radio) to reach specific audiences and to get unpaid coverage in the press. They should also use regional and local networks (as appropriate) to generate as much publicity as possible.

(Contd over)

<p>Recommendation 3 (campaign strategies), contd:</p>	<ul style="list-style-type: none"> ▪ Effective practice, including effective local and regional media messages, should be shared locally, regionally and nationally. ▪ Campaigns should run for 3–5 years. ▪ Use process and outcome measures to ensure campaigns are being delivered correctly and effectively. For recommendations on the principles of evaluation, see 'Behaviour change at population, community and individual levels' (NICE public health guidance 6).
<p>Evidence base for Recommendation 3 (campaign strategies):</p>	<ol style="list-style-type: none"> 1. <u>Evidence statement 1</u> There is evidence that mass-media campaigns can prevent the uptake of smoking and also influence knowledge, attitudes and intentions of children and young people. Factors that have been shown to influence effectiveness in terms of attitudes, perceptions, beliefs and intentions include message source, message content, message format, message framing, duration, target audience, demographics of the audience, and the site/setting of the campaign. Factors that have been shown to influence effectiveness in terms of smoking behaviour (ie smoking in the past 30 days, decreased initiation of smoking, quitting, number of cigarettes smoked) include message content, target audience, duration of the mass-media campaign, demographics of the audience, the number of anti-tobacco message sources and the Truth campaign. Overall, the factors outlined above work best when combined with broader tobacco control initiatives produced by tobacco control bodies. Furthermore, campaigns are most effective when they are long in duration and greater in intensity of exposure. 2. <u>Evidence statement 1.3.2</u> Studies analysed the effectiveness of a variety of mass-media formats. One cross-sectional (-) study found that television advertisements were recalled more often than other formats and that viewing the advertisements increased intention to quit, though did not affect actual quit attempts. Evidence from one qualitative (+) study indicates that young people deemed websites as effective in obtaining information on smoking, if they incorporated: interactivity, expert-trusted guidance, and appealing graphics. One (+) cross-sectional study reveals that youth-led tobacco prevention movements and intensive counter-marketing media campaigns can be effective in preventing the uptake of smoking and 'generating negative attitudes about the [tobacco] industry'. <u>Applicability:</u> all three studies were conducted in the USA. Given that the findings are in response to specific USA interventions, it is not clear if findings are applicable to the UK.

<p>Evidence base for Recommendation 3 (campaign strategies), contd:</p>	<p>3. <u>Evidence statement 1.3.3</u> Evidence from one cross-sectional (+) study and one (+) review suggest that adult-focused or general population campaigns are successful in reducing smoking (cutting down the number of cigarettes smoked, increasing the numbers attempting to quit, making it easier to stay a non-smoker) in young people. Yet, one (+) review contends that both messages aimed at young people and general messages can be effective in developing awareness, and changing attitudes and behaviours associated with tobacco use, as long as messages are not deemed patronising by the young. <u>Applicability:</u> no studies were conducted in the UK. It is not clear if the findings are directly relevant to the UK.</p> <p>4. <u>Evidence statement 1.4</u> There was a lack of information regarding whether the effectiveness of a mass-media intervention depends on the status of the person delivering it. However, evidence indicates that young people who receive anti-smoking messages from a variety of sources (eg family, friends, internet, sporting events), as opposed to only a few, are more likely to refuse tobacco.</p> <p>5. <u>Evidence statement 1.4.1</u> No studies specifically discussed how the status of a person delivering an intervention can have an impact on its effectiveness. Yet, one cross-sectional study (+) and one (+) review reveal that young people who are exposed to a large variety of anti-tobacco sources are more likely to refuse tobacco, and that social interactions can support anti-tobacco messaging. Evidence from two cross-sectional studies (+) indicates that the tobacco industry is not a trusted source of anti-tobacco information among young people. <u>Applicability:</u> it is not clear if the findings are directly applicable to the UK as they are USA-based. However, international review data may be broadly applicable, since multiple studies have produced similar results. Given the differences in demographics of study participants and the interventions under investigation it is not clear if findings are directly applicable to the UK.</p> <p>6. <u>Evidence statement 1.6</u> The duration of a mass-media intervention influences its effect. Increased exposure to anti-tobacco messages over time decreases intent to smoke and smoking initiation, meanwhile, increasing negative attitudes towards the tobacco industry.</p>
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<p>Evidence base for Recommendation 3 (campaign strategies), contd:</p>	<p>7. <u>Evidence statement 1.6.1</u> Evidence from one (++) Cochrane review suggests that the duration of an intervention will have the greatest bearing on health behaviours. In support of this, evidence from three cross-sectional studies (one [++] and two [+]) identified by the literature search, reveals that increased exposure to anti-smoking advertisements over time results in a decrease in: young people smoking in the past 30 days (compared to those in markets with no exposure to state-sponsored anti-tobacco laws), intent to smoke, initiation of smoking, enhanced perception of risk, and negative attitudes about smoking. Similarly, two cross-sectional (+) US studies demonstrate that young people living in states with aggressive counter-industry media campaigns are more likely to have 'negative beliefs about tobacco industry practices', are less likely to smoke, and are more informed about the dangers of second-hand smoke. As well, one (+) cohort study found that pro-tobacco media increased susceptibility to smoking, while anti-tobacco media decreased susceptibility. Conversely, one (++) US-based cross-sectional study did not find a relationship between exposure to anti-smoking campaigns and improved ideas about smoking or health behaviours. They argue that in order to be effective, exposure must be supported by other tobacco control initiatives. A cross-sectional (++) study found increased exposure to anti-tobacco mass-media messages in the absence of school-based tobacco prevention measures was not successful in reducing tobacco use among adolescents. <u>Applicability:</u> none of the studies was conducted in the UK. However, given the nature of exposure to mass-media campaigns, findings may be applicable to the UK.</p> <p>8. <u>Evidence statement 1.6.2</u> Results from four cross-sectional studies (two [++] and two [+]) indicate that the Truth campaign was successful in improving the prevention of youth smoking over time. Studies show that the campaign resulted in: decreased prevalence rates of smoking in young people (through reduced uptake and/or increased quitting), greater agreement with anti-smoking statements by young people, and stronger anti-tobacco attitudes and beliefs. <u>Applicability:</u> The Truth campaign is a USA anti-tobacco mass-media campaign. Due to the nature of the campaign and the demographics of US young people, results are not directly relevant to the UK.</p> <p>9. <u>Evidence statement 1.8</u> Lack of exposure and longevity are barriers to effective mass-media interventions.</p>
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<p>Evidence base for Recommendation 3 (campaign strategies), contd:</p>	<p>10. <u>Evidence statement 1.8.1</u> No studies specifically examined facilitators or barriers to the implementation of mass-media interventions. Yet, two (+) reviews suggest that mass-media interventions are most effective when they are longer in duration and greater in intensity of exposure. One review cites the guidelines developed by the Centre for Disease Control which recommend that advertisements should be aired for a minimum of 6 months to affect awareness and up to 24 months to have an impact on behaviours; advertisements should also be aired as frequently as possible, particularly within the first 6 months of a campaign. The other review contends that mass-media interventions should be large, intense and of 'sufficient duration' but the duration or intensity have not been explicitly defined. <u>Applicability:</u> both studies were conducted in the USA. However, given the nature of exposure to mass-media campaigns findings may be applicable to the UK.</p> <p>11. <u>Evidence statement FG1</u> On the basis of young people's recognition of the format, television campaigns should be continued to be funded as part of comprehensive prevention and cessation campaigns.</p> <p>12. <u>Evidence statement FG2</u> There was evidence to suggest that national smoking prevention campaigns with both adult and young person-oriented messages would be successful approaches for reducing smoking.</p> <p>13. <u>Evidence statement FG3</u> Health promotion campaigns using the Internet will benefit from cutting-edge design and programming.</p> <p>14. <u>Evidence statement FG4</u> Social networking and communication sites may be useful hosts of electronic smoking prevention interventions. However, these should be well designed 'click-through adverts' with clear NHS branding, rather than dedicated pages within the sites.</p>
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HS Comments/Conclusions on Recommendation 3 (campaign strategies):

1. Supported subject to: 1) adaptation to fit Scottish scale, organisational arrangements/responsibilities and professional roles; 2) amendment of the sixth main bulleted action point from 'Campaigns should run for 3-5 years' to 'Campaigns should be planned to run for at least 2 years, to be monitored and evaluated, and to be continued and/or developed for as long as they appear to be contributing effectively to the overall strategy'; 3) in the Scottish context, replacement of reference to NICE public health guidance 6 in the last main bulleted action point with "see the NHS Health Scotland Commentary on NICE Public Health Guidance 6 – 'Behaviour change at population, community and individual levels' – available at www.healthscotland.com/scotlands-health/evidence/NICE.aspx"; 4) addition of the following HS Note at the end of the third bulleted main action point – 'There is a need to consider that the potential impact of health education television advertisements on children and young people may have been weakened in the last 10 years with the emergence of newer modes of communication, such as web- and mobile telephone-based; and there is need for caution in assuming that evidence relating to health education television advertising can be extrapolated to newer media.'
2. Scottish contextual point – Existing sub-national infrastructure in Scotland relevant to tobacco prevention activities includes local tobacco control alliances (see www.ashscotland.org.uk/ash/5144.781.781.html), and youth/tobacco-related posts in some NHS Boards.

B. Illegal sales	
Recommendation 4 (illegal sales):	<p><u>Target population</u></p> <ul style="list-style-type: none"> ▪ Children and young people under 18. <p><u>Who should take action?</u></p> <ul style="list-style-type: none"> ▪ National government. <p><u>What action should they take?</u></p> <ul style="list-style-type: none"> ▪ Support better enforcement of existing legislation by: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ 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.

<p>Evidence base for Recommendation 4 (illegal sales):</p>	<ol style="list-style-type: none"> 1. <u>Evidence statement 2</u> There is evidence that access restriction interventions impact effectiveness in terms of the number of sales to young people, young people's ability to access cigarettes and store clerk compliance. There was a lack of information regarding whether interventions impact behaviours, attitudes, beliefs, intentions or perceptions. Only two studies addressed the impact of interventions on smoking behaviour. Factors that have been shown to influence number of sales, young people's ability to access cigarettes and store clerk compliance include active enforcement, comprehensive interventions, interventions produced by tobacco control bodies, requesting age/proof of ID, demographics of the vendor/store clerk, site/setting of the access intervention, and the demographics of the target audience. Overall, the factors outlined above work best when combined with requesting proof of age/ID, active enforcement (in relation to both retailer-youth purchaser and trading standards-retailers) and other youth prevention strategies. 2. <u>Evidence statement 2.1</u> Some access restrictions appear to be more effective than others. Compared to interventions created by tobacco control bodies, interventions produced by the tobacco industry do not decrease the sale of tobacco to young people. Store clerks participating in the tobacco industry intervention were still willing to illegally sell tobacco to children even after state mandated warnings were issued. 3. <u>Evidence statement 2.1.1</u> One cross-sectional (–) article found that a tobacco industry sponsored campaign in the US did not significantly reduce the sale of tobacco to minors, yet state mandated warnings were only slightly more successful in reducing young people's ability to purchase tobacco. Tobacco industry interventions may not prevent the illegal sale of tobacco to children and young people; active enforcement of tobacco sales laws by health officials may be more effective. <u>Applicability:</u> findings are not applicable to the UK since the findings are specific to a US-based tobacco industry campaign. 4. <u>Evidence statement 2.2.1</u> No studies in the review examined whether interventions were delaying rather than preventing the onset of smoking. For the most part, studies examined the effect of access restrictions on illegal sales (eg number of sales to youth, merchant compliance) not the effect on behaviour or prevention of uptake. One US-based cross-sectional study (+) did find that interventions impacted youth's stage of smoking uptake. Stage of smoking uptake was rated on a continuum of 1 to 5, with stage 1 being someone who has never smoked and has no intention to smoke, and stage 5 being someone who currently smokes,
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<p>Evidence base for Recommendation 4 (illegal sales), contd:</p>	<p>has smoked at least 100 cigarettes and has no intention to quit. Evidence from this study suggests that compliance with youth access laws reduces the probability of being in higher stages of smoking. Youth who are in earlier stages of smoking depend more on social sources for acquiring tobacco. Interestingly, evidence from one American review (+) shows no difference in youth smoking rates between communities with and without greater merchant compliance with sales restrictions.</p> <p><u>Applicability:</u> the findings are in relation to two US-specific interventions. It is not clear if findings are directly applicable to the UK.</p> <p>5. <u>Evidence statement 2.3</u> The way in which an intervention is delivered does influence effectiveness. There is strong evidence that comprehensive interventions are more effective than individual restrictions alone. Furthermore, active enforcement and requesting age/ID can also decrease sales of tobacco. Similar findings were highlighted from English survey data.</p> <p>6. <u>Evidence statement 2.3.1</u> One (++) Cochrane review and one US-based cross-sectional study (+) found that multi-faceted interventions (active enforcement, multi-component educational strategies, and increased taxing and restrictions on smoking in public places respectively) are most effective for reducing youth's ability to access tobacco, particularly when combined with ongoing and active enforcement of minimum age restrictions. Similarly, English survey data indicates that a broad set of actions is the key to successfully increasing compliance with minimum age laws. Active law enforcement has been identified by one review (+) and two cross-sectional studies (-) as an important part of multi-component interventions. Evidence from one review (+) suggests that vending machine policies are most effective at reducing youth access to tobacco when combined with locking devices or complete vending machine bans.</p> <p><u>Applicability:</u> the majority of the studies took place outside of the UK in a wide range of countries, including Australia, the USA and New Zealand. However, it is likely that their findings are applicable to the UK, given the broad similarities in the impact of enforcement.</p> <p>7. <u>Evidence statement 2.3.2</u> Two cross-sectional (+) US-based studies found that when store clerks requested proof of age, illegal sales decreased. There is some evidence that asking for identification decreases illegal sales more than asking for age. Yet evidence from a non-RCT study (+) in the US suggests that minors who present ID are more successful when purchasing tobacco than those who do not. Therefore, while cashier compliance with enforcing age restrictions can decrease young people's ability to purchase tobacco, evidence suggests that this will be most effective when</p>
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<p>Evidence base for Recommendation 4 (illegal sales), contd:</p>	<p>stringent verification of ID occurs. <u>Applicability:</u> as none of these studies was conducted in the UK it is not clear if findings are directly applicable.</p> <p>8. <u>Evidence statement 2.4</u> The status of the person delivering an access restriction does impact on effectiveness. The age, gender and ethnicity of shop assistants selling tobacco appear to influence sales to young people.</p> <p>9. <u>Evidence statement 2.4.1</u> In one cross-sectional study (+), store clerks participating in a compliance programme were as likely to make illegal sales of tobacco to young people as store clerks who were not participating in the programme. However, US-based evidence from one (+) non-RCT and two cross-sectional (+) studies suggests that the age, gender and ethnicity of the person delivering an intervention influences the outcomes. Overall, younger store clerks are more likely to sell tobacco illegally to a minor, identification is less likely to be requested and an illegal sale is more likely to occur when the store clerk is a man. Some evidence also suggests that ethnicity may influence intervention outcomes; Asian clerks were found more likely to request age, with white store clerks most often requesting identification. <u>Applicability:</u> all four studies were conducted in the USA. It is not clear if findings are applicable to the UK.</p> <p>10. <u>Evidence statement 2.5</u> Evidence shows that the site/setting does influence effectiveness. Based on English survey data, young people are successful at buying tobacco in a variety of locations including newsagents, tobacconists or sweet shops. Similar findings were highlighted by US studies which found that young people buy cigarettes from convenience stores, gas stations and food stores. One Tasmanian study also found that youth are successful in purchasing cigarettes from a variety of locations, including: service stations, supermarkets and corner stores.</p> <p>11. <u>Evidence statement 2.5.1</u> Evidence shows that site/setting does influence the effectiveness of the intervention, and youth's ability to purchase tobacco. Evidence from one cross-sectional (+) study in Sweden indicates that younger looking adolescents were most successful when purchasing tobacco from newsstands, tobacconists and service stations (compared to department stores, grocery stores, cafes, restaurants, and video rental shops). Survey data from England indicates that young people close to the legal purchase age (older young people) are more successful at purchasing cigarettes than their younger counterparts. Another cross-sectional study (++) in the US found that minors were most successful at purchasing tobacco in convenience stores, followed by gas stations and food stores. One Tasmanian cross-sectional (+) study also found that youth are successful in purchasing cigarettes from a variety of locations, including: service stations, supermarkets</p>
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<p>Evidence base for Recommendation 4 (illegal sales), contd:</p>	<p>and corner stores. Survey data from England similarly indicates that young people often buy cigarettes from newsagents, tobacconists or sweet shops. The availability of tobacco vending machines also influences access to tobacco. Two (+) cross-sectional studies based in the US, found that young people were more successful when purchasing tobacco from unlocked vending machines or self-service displays than from locked vending machines or over-the-counter outlets.</p> <p><u>Applicability:</u> all five studies took place outside of the UK. However, it is likely that their findings are applicable to the UK given the broad similarities in the locations where young people purchase cigarettes.</p> <p>12. <u>Evidence statement 2.6</u> The duration of access restrictions may impact effectiveness. There is some evidence that compliance with access restrictions increases over time. However, effectiveness may not be self-sustainable and may be impacted by social sources of tobacco.</p> <p>13. <u>Evidence statement 2.6.1</u> No studies in the review directly studied the intensity of interventions, although some did examine the impact of an intervention over time. Evidence from two (+) cross-sectional studies indicate that over time (between 2001 and 2003, and between 1996 and 2005 respectively) factors such as successive retail inspections, public prosecutions, awareness of campaigns and implementing a minimum-age law, result in decreased illegal sales of tobacco. Yet, evidence from one (+) review demonstrates that the effectiveness of access restrictions on purchasing tobacco may depend on the level of implementation (level of fines, rate of compliance, community involvement). Lastly, according to evidence from a (+) empirical review, interventions may not produce a sustained decrease in the illegal sale of tobacco. The authors do not specify the impact of the interventions on duration of effect; they only state that interventions without compliance checks, significant penalties, and store clerk awareness have limited long-term effects. Similarly, findings from one (+) cross-sectional study in Tasmania showed a decrease in non-compliance over time.</p> <p><u>Applicability:</u> all five studies took place outside of the UK. As a result, it is not clear if findings are directly applicable.</p> <p>14. <u>Evidence statement 2.7</u> The effectiveness of access restrictions is affected by a variety of demographic variables. Those close to the legal minimum age (older youth) and more established smokers (who are also likely to be older) are more successful at purchasing tobacco. Although there were mixed findings regarding the impact of sex, findings from a strong piece of evidence indicate that boys are more successful than girls at purchasing tobacco. However, English survey data indicates that girls are more likely to try</p>
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<p>Evidence base for Recommendation 4 (illegal sales), contd:</p>	<p>and buy cigarettes. However, refusal rates, and therefore purchasing success rates, are similar for boys and girls. The ethnicity of the young person influenced whether or not age/ID was requested. There was a lack of information regarding the impact of socioeconomic status.</p> <p>15. <u>Evidence statement 2.7.1</u> Access restrictions on the sale of tobacco have an impact on people who smoke in different ways, depending on their age and smoking status. Evidence from one (++) Cochrane review reveals that regular smokers encounter access restrictions on the sale of tobacco more frequently, but also employ more techniques to obtain cigarettes—such as presenting fake ID or lying about their age. One Australian-based cross-sectional (-) study found that retailer compliance resulted in the greatest decrease in smoking behaviour for younger and less experienced smokers. Eg, the number of regular smokers decreased, the number of young people reporting at least monthly smoking decreased and the frequency of smoking decreased. Similarly, there is some US-based evidence from one (+) cross-sectional study, one (4 +) non-randomised controlled trial study, and one (++) cross-sectional study that young people close to the legal minimum age (older youth) are more successful in purchasing tobacco. Some evidence also suggests that the youth's age or appearance affects their ability to purchase tobacco. Two (+) cross-sectional studies and survey data from England found that young people who appear older are more successful in purchasing tobacco than those who look younger.</p> <p><u>Applicability:</u> although all of these studies took place outside of the UK, it is likely that their findings are applicable to the UK, given the outcomes being measured.</p> <p>16. <u>Evidence statement 2.7.2</u> Evidence from one US cross-sectional study (++) found that males had greater purchasing success rates. English survey data indicates that girls try to purchase cigarettes more than boys, however, refusal rates and therefore purchasing success rates, are similar. Evidence from two (+) Swedish cross-sectional studies indicate that boys were more successful in purchasing tobacco, both before and after minimum age restrictions were applied. Conversely, one US (+) cross-sectional study suggests girls are more successful in buying tobacco and one (+) cross-sectional study found that girls were more frequently asked to present ID when attempting to buy cigarettes. Some evidence also suggests that requesting ID results in the greatest reduction of girl's access to purchasing cigarettes.</p> <p><u>Applicability:</u> all five studies took place outside the UK. Furthermore, some evidence is not consistent with English survey data. Findings may not be directly relevant to the UK.</p>
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<p>Evidence base for Recommendation 4 (illegal sales), contd:</p>	<p>17. <u>Evidence statement 2.7.3</u> Evidence indicates that ethnicity influences the ability to buy tobacco among young people. One US (+) cross-sectional study found that African American children, followed by Latino and white children respectively, were more likely to be asked for ID when attempting to purchase cigarettes. ID requests resulted in the greatest reduction of African American children's success in purchasing cigarettes. The authors do not indicate whether or not ID requests resulted in a reduction of purchasing success for Hispanic or white youths. One US-based (+) cross-sectional study found that tobacco policies impact young people differently. Evidence shows that smoking rates for white male young people are more responsive to anti-tobacco activities and clean indoor restrictions, while young black males are more influenced by smoking protection and youth access laws (ie purchasing restrictions). <u>Applicability:</u> as these studies deal with specific populations in the USA, it is unclear how applicable these findings are to a UK setting.</p> <p>18. <u>Evidence statement 2.8</u> Acquiring tobacco from social sources and lack of enforcement are barriers to the effective implementation of access restrictions.</p> <p>19. <u>Evidence statement 2.8.1</u> Two key barriers to the implementation of access restrictions on purchasing tobacco were identified. Evidence from three (+) reviews and one (++) review indicates that access restrictions are impeded by a young person's ability to access tobacco products from social sources including friends, family, and strangers. English survey data reveals similar findings. Furthermore, evidence from one (+) cross-sectional study based in the USA shows that weak enforcement of laws and policies creates a barrier to the effective reduction of the number of young people who smoke. In particular, minimum age restrictions are not well enforced. <u>Applicability:</u> although the studies were conducted in the USA, their results are likely to be broadly applicable to the UK setting.</p> <p>20. <u>Evidence statement FG9</u> Young people aged under 18 are able to obtain cigarettes from a wide variety of sources that circumvent legal controls. Proof of age schemes will not be effective for young people who obtain contraband or illegally imported cigarettes. Furthermore, young people are able to purchase cigarettes online with minimum information checking by retailers. Proof of age schemes need to be supported by test purchasing and enforcement.</p>
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HS Comments/Conclusions on Recommendation 4 (illegal sales):

1. Supported subject to: 1) adaptation to fit Scottish governmental, legal and organisational arrangements/responsibilities/roles, including recognition that the Local Better Regulation Office has no responsibilities in connection with tobacco sales in Scotland; 2) deletion of the bulleted action sub-point 'ensuring magistrates are aware...', having noted that cases of alleged under-age tobacco sales in Scotland are considered for appropriate action by Procurators Fiscal and may be heard at Sheriff Courts/by Sheriffs, that the Criminal Justice and Immigration Act will not apply to tobacco sales in Scotland, and that relevant existing Scottish legislation is currently under review; 3) insertion of the following HS Note at the end of the Recommendation – 'The illegal sale of illicit (contraband or smuggled) tobacco is a matter for HM Revenue & Customs (HMRC) rather than Local Authorities.'
2. Scottish contextual point – A Practical Guide to Test Purchasing in Scotland (The Scottish Government, 2007) sets out guidance for authorities and agencies (mainly Local Authorities and Police Forces) involved in the conduct of test purchasing operations involving children and young people and the sale of age-restricted products/goods (see www.scotland.gov.uk/Publications/2007/10/25155751).

Recommendation 5 (illegal sales):

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.

(Contd over)

<p>Recommendation 5 (illegal sales), contd:</p>	<ul style="list-style-type: none"> ▪ 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 to prevent under-age sales by: <ul style="list-style-type: none"> - 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 (eg, 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.
<p>Evidence base for Recommendation 5 (illegal sales):</p>	<p>1. <u>Evidence statement 2</u> There is evidence that access restriction interventions impact effectiveness in terms of the number of sales to young people, young people’s ability to access cigarettes and store clerk compliance. There was a lack of information regarding whether interventions impact behaviours, attitudes, beliefs, intentions or perceptions. Only two studies addressed the impact of interventions on smoking behaviour. Factors that have been shown to influence number of sales, young people’s ability to access cigarettes and store clerk compliance include active enforcement, comprehensive interventions, interventions produced by tobacco control bodies, requesting age/proof of ID, demographics of the vendor/store clerk, site/setting of the</p>

<p>Evidence base for Recommendation 5 (illegal sales), contd:</p>	<p>access intervention, and the demographics of the target audience. Overall, the factors outlined above work best when combined with requesting proof of age/ID, active enforcement (in relation to both retailer-youth purchaser and trading standards-retailers) and other youth prevention strategies.</p> <ol style="list-style-type: none"> 2. <u>Evidence statement 2.1</u> Some access restrictions appear to be more effective than others. Compared to interventions created by tobacco control bodies, interventions produced by the tobacco industry do not decrease the sale of tobacco to young people. Store clerks participating in the tobacco industry intervention were still willing to illegally sell tobacco to children even after state mandated warnings were issued. 3. <u>Evidence statement 2.1.1</u> One cross-sectional (–) article found that a tobacco industry sponsored campaign in the US did not significantly reduce the sale of tobacco to minors, yet state mandated warnings were only slightly more successful in reducing young people’s ability to purchase tobacco. Tobacco industry interventions may not prevent the illegal sale of tobacco to children and young people; active enforcement of tobacco sales laws by health officials may be more effective. <u>Applicability:</u> findings are not applicable to the UK since the findings are specific to a US-based tobacco industry campaign. 4. <u>Evidence statement 2.3</u> The way in which an intervention is delivered does influence effectiveness. There is strong evidence that comprehensive interventions are more effective than individual restrictions alone. Furthermore, active enforcement and requesting age/ID can also decrease sales of tobacco. Similar findings were highlighted from English survey data. 5. <u>Evidence statement 2.3.1</u> One (++) Cochrane review and one US-based cross-sectional study (+) found that multi-faceted interventions (active enforcement, multi-component educational strategies, and increased taxing and restrictions on smoking in public places respectively) are most effective for reducing youth’s ability to access tobacco, particularly when combined with ongoing and active enforcement of minimum age restrictions. Similarly, English survey data indicates that a broad set of actions is the key to successfully increasing compliance with minimum age laws. Active law enforcement has been identified by one review (+) and two cross-sectional studies (-) as an important part of multi-component interventions. Evidence from one review (+) suggests that vending machine policies are most effective at reducing youth access to tobacco when combined with locking devices or complete vending machine bans. <u>Applicability:</u> the majority of the studies took place outside of
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<p>Evidence base for Recommendation 5 (illegal sales), contd:</p>	<p>the UK in a wide range of countries, including Australia, the USA and New Zealand. However, it is likely that their findings are applicable to the UK, given the broad similarities in the impact of enforcement.</p> <p>6. <u>Evidence statement 2.3.2</u> Two cross-sectional (+) US-based studies found that when store clerks requested proof of age, illegal sales decreased. There is some evidence that asking for identification decreases illegal sales more than asking for age. Yet evidence from a non-RCT study (+) in the US suggests that minors who present ID are more successful when purchasing tobacco than those who do not. Therefore, while cashier compliance with enforcing age restrictions can decrease young people's ability to purchase tobacco, evidence suggests that this will be most effective when stringent verification of ID occurs. <u>Applicability:</u> as none of these studies was conducted in the UK it is not clear if findings are directly applicable.</p> <p>7. <u>Evidence statement 2.4</u> The status of the person delivering an access restriction does impact on effectiveness. The age, gender and ethnicity of shop assistants selling tobacco appear to influence sales to young people.</p> <p>8. <u>Evidence statement 2.4.1</u> In one cross-sectional study (+), store clerks participating in a compliance programme were as likely to make illegal sales of tobacco to young people as store clerks who were not participating in the programme. However, US-based evidence from one (+) non-RCT and two cross-sectional (+) studies suggests that the age, gender and ethnicity of the person delivering an intervention influences the outcomes. Overall, younger store clerks are more likely to sell tobacco illegally to a minor, identification is less likely to be requested and an illegal sale is more likely to occur when the store clerk is a man. Some evidence also suggests that ethnicity may influence intervention outcomes; Asian clerks were found more likely to request age, with white store clerks most often requesting identification. <u>Applicability:</u> all four studies were conducted in the USA. It is not clear if findings are applicable to the UK.</p> <p>9. <u>Evidence statement 2.5</u> Evidence shows that the site/setting does influence effectiveness. Based on English survey data, young people are successful at buying tobacco in a variety of locations including newsagents, tobacconists or sweet shops. Similar findings were highlighted by US studies which found that young people buy cigarettes from convenience stores, gas stations and food stores. One Tasmanian study also found that youth are successful in purchasing cigarettes from a variety of locations, including: service stations, supermarkets and corner stores.</p>
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<p>Evidence base for Recommendation 5 (illegal sales), contd:</p>	<p>10. <u>Evidence statement 2.5.1</u> Evidence shows that site/setting does influence the effectiveness of the intervention, and youth's ability to purchase tobacco. Evidence from one cross-sectional (+) study in Sweden indicates that younger looking adolescents were most successful when purchasing tobacco from newsstands, tobacconists and service stations (compared to department stores, grocery stores, cafes, restaurants, and video rental shops). Survey data from England indicates that young people close to the legal purchase age (older young people) are more successful at purchasing cigarettes than their younger counterparts. Another cross-sectional study (++) in the US found that minors were most successful at purchasing tobacco in convenience stores, followed by gas stations and food stores. One Tasmanian cross-sectional (+) study also found that youth are successful in purchasing cigarettes from a variety of locations, including: service stations, supermarkets and corner stores. Survey data from England similarly indicates that young people often buy cigarettes from newsagents, tobacconists or sweet shops. The availability of tobacco vending machines also influences access to tobacco. Two (+) cross-sectional studies based in the US, found that young people were more successful when purchasing tobacco from unlocked vending machines or self-service displays than from locked vending machines or over-the-counter outlets.</p> <p><u>Applicability:</u> all five studies took place outside of the UK. However, it is likely that their findings are applicable to the UK given the broad similarities in the locations where young people purchase cigarettes.</p> <p>11. <u>Evidence statement 2.6</u> The duration of access restrictions may impact effectiveness. There is some evidence that compliance with access restrictions increases over time. However, effectiveness may not be self-sustainable and may be impacted by social sources of tobacco.</p> <p>12. <u>Evidence statement 2.6.1</u> No studies in the review directly studied the intensity of interventions, although some did examine the impact of an intervention over time. Evidence from two (+) cross-sectional studies indicate that over time (between 2001 and 2003, and between 1996 and 2005 respectively) factors such as successive retail inspections, public prosecutions, awareness of campaigns and implementing a minimum-age law, result in decreased illegal sales of tobacco. Yet, evidence from one (+) review demonstrates that the effectiveness of access restrictions on purchasing tobacco may depend on the level of implementation (level of fines, rate of compliance, community involvement). Lastly, according to evidence from a (+)</p>
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<p>Evidence base for Recommendation 5 (illegal sales), contd:</p>	<p>empirical review, interventions may not produce a sustained decrease in the illegal sale of tobacco. The authors do not specify the impact of the interventions on duration of effect; they only state that interventions without compliance checks, significant penalties, and store clerk awareness have limited long-term effects. Similarly, findings from one (+) cross-sectional study in Tasmania showed a decrease in non-compliance over time.</p> <p><u>Applicability:</u> all five studies took place outside of the UK. As a result, it is not clear if findings are directly applicable.</p> <p>13. <u>Evidence statement 2.7</u> The effectiveness of access restrictions is affected by a variety of demographic variables. Those close to the legal minimum age (older youth) and more established smokers (who are also likely to be older) are more successful at purchasing tobacco. Although there were mixed findings regarding the impact of sex, findings from a strong piece of evidence indicate that boys are more successful than girls at purchasing tobacco. However, English survey data indicates that girls are more likely to try and buy cigarettes. However, refusal rates, and therefore purchasing success rates, are similar for boys and girls. The ethnicity of the young person influenced whether or not age/ID was requested. There was a lack of information regarding the impact of socioeconomic status.</p> <p>14. <u>Evidence statement 2.7.1</u> Access restrictions on the sale of tobacco have an impact on people who smoke in different ways, depending on their age and smoking status. Evidence from one (++) Cochrane review reveals that regular smokers encounter access restrictions on the sale of tobacco more frequently, but also employ more techniques to obtain cigarettes - such as presenting fake ID or lying about their age. One Australian-based cross-sectional (-) study found that retailer compliance resulted in the greatest decrease in smoking behaviour for younger and less experienced smokers. Eg, the number of regular smokers decreased, the number of young people reporting at least monthly smoking decreased and the frequency of smoking decreased. Similarly, there is some US-based evidence from one (+) cross-sectional study, one (4 +) non-randomised controlled trial study, and one (++) cross-sectional study that young people close to the legal minimum age (older youth) are more successful in purchasing tobacco. Some evidence also suggests that the youth's age or appearance affects their ability to purchase tobacco. Two (+) cross-sectional studies and survey data from England found that young people who appear older are more successful in purchasing tobacco than those who look younger.</p> <p><u>Applicability:</u> although all of these studies took place outside</p>
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<p>Evidence base for Recommendation 5 (illegal sales), contd:</p>	<p>of the UK, it is likely that their findings are applicable to the UK, given the outcomes being measured.</p> <p>15. <u>Evidence statement 2.7.2</u> Evidence from one US cross-sectional study (++) found that males had greater purchasing success rates. English survey data indicates that girls try to purchase cigarettes more than boys, however, refusal rates and therefore purchasing success rates, are similar. Evidence from two (+) Swedish cross-sectional studies indicate that boys were more successful in purchasing tobacco, both before and after minimum age restrictions were applied. Conversely, one US (+) cross-sectional study suggests girls are more successful in buying tobacco and one (+) cross-sectional study found that girls were more frequently asked to present ID when attempting to buy cigarettes. Some evidence also suggests that requesting ID results in the greatest reduction of girl's access to purchasing cigarettes.</p> <p><u>Applicability:</u> all five studies took place outside the UK. Furthermore, some evidence is not consistent with English survey data. Findings may not be directly relevant to the UK.</p> <p>16. <u>Evidence statement 2.7.3</u> Evidence indicates that ethnicity influences the ability to buy tobacco among young people. One US (+) cross-sectional study found that African American children, followed by Latino and white children respectively, were more likely to be asked for ID when attempting to purchase cigarettes. ID requests resulted in the greatest reduction of African American children's success in purchasing cigarettes. The authors do not indicate whether or not ID requests resulted in a reduction of purchasing success for Hispanic or white youths. One US-based (+) cross-sectional study found that tobacco policies impact young people differently. Evidence shows that smoking rates for white male young people are more responsive to anti-tobacco activities and clean indoor restrictions, while young black males are more influenced by smoking protection and youth access laws (ie purchasing restrictions).</p> <p><u>Applicability:</u> as these studies deal with specific populations in the USA, it is unclear how applicable these findings are to a UK setting.</p> <p>17. <u>Evidence statement FG9</u> Young people aged under 18 are able to obtain cigarettes from a wide variety of sources that circumvent legal controls. Proof of age schemes will not be effective for young people who obtain contraband or illegally imported cigarettes. Furthermore, young people are able to purchase cigarettes online with minimum information checking by retailers. Proof of age schemes need to be supported by test purchasing and enforcement.</p>
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HS Comments/Conclusions on Recommendation 5 (illegal sales):

1. Supported subject to: 1) adaptation to fit Scottish governmental, legal and organisational arrangements/responsibilities/roles, including recognition that the Local Better Regulation Office has no responsibilities in connection with tobacco sales in Scotland; 2) replacement (in 'Who should take action?') of 'local authorities and trading standards bodies' with 'Local Authorities, including their Trading Standards Services'; 3) replacement of 'prosecuting retailers who persistently break the law' (second main bulleted action point, first sub-point) with 'reporting to the Procurator Fiscal retailers who knowingly or persistently break the law'; 4) insertion of the following HS Note after the sub-point concerned with requesting proof of age – 'Trading Standards Services in Scotland suggest, on a precautionary basis, that proof of age be requested from anyone who appears younger than 21 who attempts to buy cigarettes.'.
2. Scottish contextual point - A Practical Guide to Test Purchasing in Scotland (The Scottish Government, 2007) sets out guidance for authorities and agencies (mainly Local Authorities and Police Forces) involved in the conduct of test purchasing operations involving children and young people and the sale of age-restricted products/goods (see www.scotland.gov.uk/Publications/2007/10/25155751/2).

NICEPHG014 Recommendations for Research, and HS Comments/Conclusions

<p>Recommendations for Research:</p>	<p>NICEPHG014 recommends that the following research questions should be addressed to improve the evidence relating to mass-media and point-of-sales measures to prevent smoking uptake by children and young people. It indicates that 'effectiveness' in this context should be taken to relate not only to the size of the effect, but also to cost effectiveness, duration of effect and harmful/negative effects.</p> <ol style="list-style-type: none">1. Can interventions using new media help delay and/or prevent the uptake of smoking among children and young people in the UK?2. What impact do socioeconomic factors (such as the social class of the target population) have on the effectiveness mass-media campaigns?3. Would the US-based 'Truth' campaign be effective in the UK? (For details, see the report of the effectiveness evidence review 'Interventions to prevent the uptake of smoking in children and young people', at www.nice.org.uk/PH014).4. What impact do socioeconomic factors (such as the social class of the target population) have on the effectiveness of measures to reduce illegal sales?5. Do UK purchasing restrictions lead children and young people under 18 to buy cigarettes from unofficial sources? If so, how much tobacco are they buying from them and where are these sources?
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HS Comments/Conclusions on Recommendations for Research:

1. *Supported.*

Members of Reference Group for NHS Health Scotland Commentary on NICE Public Health Guidance 14

- Ms Philippa Bonella, Director of Information and Communications, ASH Scotland
- Ms Chrissie Fairclough, Head of Corporate Communication, NHS Health Scotland
- Prof Gerard Hastings, Professor of Social Marketing and Director of the Institute for Social Marketing and the Cancer Research UK Centre for Tobacco Control Research, University of Stirling and Open University
- Ms Nuala Healy, Health Improvement Programme Manager (Young People), NHS Health Scotland
- Ms Kerry McKenzie, Health Improvement Programme Manager (Tobacco), NHS Health Scotland
- Mr David Thomson, Chief Trading Standards Officer, South Ayrshire Council and Chair of SCOTSS (Society of Chief Officers of Trading Standards in Scotland)
- Miss Anna Wallace, when Policy Manager, Tobacco Control Unit, The Scottish Government