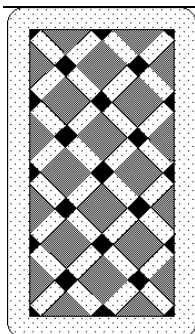

**RAPID REVIEW OF EFFECTIVENESS OF INTERVENTIONS TO
SUPPORT A LONDON-WIDE TOBACCO CONTROL PROGRAMME**

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EXECUTIVE SUMMARY

Tackling tobacco is essential to London's health. There are nearly 2 million adult smokers, and the approaches which have reduced smoking over the last few decades among large sections of the population have made no difference to the poorest. Tobacco control needs concerted action across sectors, and for the first time the UK has a tobacco control strategy, *Smoking Kills*, which takes a comprehensive approach. The strategy prioritises people who want to give up, pregnant women and children and young people, and identifies clean, smoke free air in places open to the public as an area for action.

The roles of the NHS, Government and some enforcing agencies are clear in *Smoking Kills*, and other agencies have important though less defined roles. London has a great opportunity, as a very large population with a strong city identity, to undertake a city wide programme.

This review considers the evidence for the effectiveness of interventions to control tobacco at a London-wide level, because they would show economies of scale, or might be more effective with co-ordination and consistency across London, or have a natural target population which extends across all of London, or fall within the remit of a London wide authority. Other city-wide programmes have long-standing experience, and that experience informed the selection of interventions for review, although no city-wide programme covers an area with London's size or boundary complexity.

Because robust evidence is sparse, non-systematic reviews and consensus statements were considered alongside systematic reviews with more weight given to robust evidence.

Action for tobacco control in London

Changing attitudes The clearest evidence of effectiveness, and the strongest case for action across London rather than at any other level, was for interventions of all kinds which change attitudes. This includes mass media campaigns including press, TV, posters, unpaid press coverage through the generation of news stories, and events such as no smoking day, and new year and Ramadan campaigns. There are imaginative examples of this kind of work from other cities, particularly Birmingham. It is recommended that a London wide tobacco control programme develops this function immediately.

London-wide facilitation and co-ordination will enhance the impact of some tobacco control actions by London's health authorities, boroughs and voluntary sector to help smokers give up, reduce smoking in children and young people and achieve clean air in places open to the public. These include actions to change attitudes such as publicity for cessation facilities, publicity to support the voluntary charter for clean air, media coverage for prosecutions of retailers illegally selling tobacco products to children. In the medium term they could include facilitation of sharing of good practice by boroughs and health authorities, and facilitation of joint training or production of resources.

Provision of certain London-wide services could be a longer term activity for a London-wide programme. These might include cessation facilities in central London for commuters or for dispersed minority populations, pilot projects, and training of professionals. This type of activity depends on organisational development within the London programme and support from London's statutory commissioners and providers of services, to ensure that London wide added value is achieved.

Some interventions are clearly the responsibility of statutory agencies, and there is no added value in London-wide provision, co-ordination or facilitation.

Innovation is needed to reduce smoking prevalence in the *Smoking Kills* priority groups. Allowance must be made for innovations which go beyond the existing evidence base.

1. LONDON-WIDE TOBACCO CONTROL - THE POLICY QUESTIONS

Smoking is the biggest cause of preventable death and ill health in the United Kingdom, and its impact is greatest amongst the most disadvantaged. London has a similar level of smoking to the rest of the United Kingdom, and includes areas of high deprivation with correspondingly high levels of smoking and smoking-related health problems.

There is now a new comprehensive tobacco control strategy for the United Kingdom.¹ In 1962, the Royal College of Physicians of London reported on the then recent findings that tobacco causes cancer and heart disease, and spelled out the policy response that was needed (Box 1).²

Box 1: Possible action by government - Royal College of Physicians 1962²

Decisive steps should be taken by the Government to curb the present rising consumption of tobacco, and especially of cigarettes. This action could be taken along the following lines:

- i. more education of the public and especially school-children concerning the hazards of smoking;
- ii. more effective restrictions on the sale of tobacco to children;
- iii. restriction of tobacco advertising;
- iv. wider restriction of smoking in public places;
- v. an increase of tax on cigarettes, perhaps with adjustment of the tax on pipe and cigar tobaccos;
- vi. informing purchasers of the tar and nicotine content of the smoke of cigarettes;
- vii. investigating the value of anti-smoking clinics to help those who find difficulty in giving up smoking.

From the very start of widespread awareness that tobacco was harmful, therefore, it was acknowledged that tackling tobacco at individual level alone through help with cessation and education on the dangers of smoking was insufficient without public policy support such as controls on advertising and restrictions on smoking in public places. *Smoking Kills*, the UK tobacco control strategy, provides for the first time an integrated and comprehensive approach to tobacco control. The UK's approach to tobacco control now includes all the actions proposed in the Royal College of Physicians' 1962 report. The phased implementation of an advertising and promotion ban has begun. Advocacy for increased taxation has been diverted into concern about smuggling now that our high tobacco taxes relative to neighbouring countries make this activity worthwhile. Concern for the most disadvantaged smokers has become a priority, now that prevalence has fallen selectively among the more privileged and this fall in prevalence has passed the poorest by.

The *Smoking Kills* strategy was developed through a process which brought together the best evidence for effective action with expert consensus in the many areas where evidence was lacking, and addressed issues of acceptability, feasibility and cost. The strategy's aims are:

- **to halt the rise in children smoking** (judged by falls in children's smoking prevalence)
- **to establish a new downward trend in adult smoking rates in all social classes** (judged by a fall in adult smoking prevalence achieved through falls in prevalence among all social classes)
- **to improve the health of expectant mothers and their families** (judged by falls in the rate of smoking amongst pregnant women).

These aims are appropriate for London.

The strategy has broad support from tobacco control advocates and practitioners, and it is time to move on to implementation. The roles of central government and of the NHS are clear. Local government, the Health and Safety Executive and some trade associations have enforcing responsibilities for regulations and voluntary codes. These responsibilities are set out in more detail in Section 8 and Table 5 to Table 9 in the Appendix. London's public agencies are now looking at comprehensive strategic approaches to tobacco control at a London level, and identifying the actions that give 'London-wide added value'. London (16 health authorities and 33 boroughs) will soon have its own authority, and a mayor. London's vast population, including transient populations of commuters, students and tourists, its large area, its great extremes of privilege and disadvantage, its cultural diversity, and particular circumstances such as its concentration of teaching hospitals, give

London a very special character. It must develop tailored solutions to social problems such as tobacco control. The questions to be addressed are:

- What interventions to contribute to progress towards the *Smoking Kills* aims are best done at a city-wide level?
- What is the evidence for the effectiveness of city-wide interventions for tobacco-control?

2. OPERATIONALISING THE POLICY QUESTIONS

For this review, interventions are considered to contribute to the *Smoking Kills* aims of halting the rise in children's smoking, establishing a new downward trend in adult smoking across all social classes, and improving the health of expectant mothers and their families if they:

- contribute directly to reducing prevalence in these three groups in London, using the prevalence indicators in the *Smoking Kills* targets; or
- facilitate the effectiveness of actions which are to be implemented under *Smoking Kills*.

A set of criteria were developed to determine which interventions were best done at a city level.

3. METHODS

What interventions to control tobacco are best done at a city-wide level?

Interventions to control tobacco were collated from recent policy documents and recommendations, particularly *Smoking Kills*.

City-wide tobacco control programmes were identified through an appeal to the international tobacco control electronic network GLOBALink, and direct contact with city-wide initiatives. Criteria to identify interventions appropriate for London wide action were developed using:

- experience from other city-wide programmes
- competencies of statutory agencies in London
- geographic and demographic characteristics of London

What is the evidence for the effectiveness of city-wide interventions for tobacco-control?

The government's smoking strategy was based on an expert consensus exercise which considered best current knowledge and expert advice on acceptability to public and practitioners. It is not the task of this review to evaluate again the evidence on which the strategy is based, and around which broad support has been built.

Evaluations were sought of interventions which could be applied at London level, including those which support interventions led by the NHS and local authorities.

- The Cochrane Website was searched for reviews of interventions to reduce smoking prevalence in the *Smoking Kills* target groups, or to support actions with this aim, using the free text terms "smoking" and "tobacco". The search covered Cochrane reviews and the Database of Abstracts of Reviews of Effectiveness (DARE).
- Non-systematic reviews of these interventions known to the author, and others identified from the reference lists of retrieved documents were also included. The findings of these reviews may be biased or confounded, but they allow the inclusion of practitioner and expert judgement where sound evidence is lacking.

Evaluation was also sought for the concerted impact of a comprehensive programme of multi-sectoral city-wide actions.

- Medline and the Health Education Authority's database HealthPromis were searched for primary evaluations and reviews on city wide tobacco programmes using the search terms ["tobacco" or "smoking"] and ["policy" or "strategy" or "program*"] and ["city"].
- Evaluations were sought from the city wide programmes which were contacted directly, both of the initiatives as a whole, and of actions within them. Evaluations by both process measures (such as press coverage and contacts with Quitline) and outcome measures (such as changes in prevalence) were sought.

Issues of evidence review in health policy and health promotion

Evaluations of tobacco control interventions share the problems of evaluation in other areas of health policy and health promotion in that they have not been evaluated by robust methods. The randomised controlled trial is the evaluation design least beset by bias and confounding. Systematic review has been used to summarise and assess the quality of large bodies of evidence, and although systematic reviews can be applied to study designs other than randomised trials, systematic reviews of other study designs have been rare. This has led to systematic reviews reporting on interventions addressing a very narrow range of problems - the problems which can be addressed by interventions which can be evaluated using randomised controlled trials. There is a particular shortage of randomised controlled trials in health promotion and health policy:

- much of this work has been done outside the medical and health care disciplines, in fields which have different approaches to evidence from those used by the systematic review. The multi-disciplinary nature of health promotion has also led to studies not being indexed on the medical databases which are the most productive search tools of the systematic review;

- the interventions which have measurable and clearly defined outcomes appropriate for systematic review include only a very small proportion of health promotion and health policy studies, addressing problems such as how to reduce specific diseases or risk behaviours by discrete, self-contained actions. A range of multi-sectoral, concerted programmes, and projects addressing a range of outcomes lack the tidy structure best suited to the systematic review.

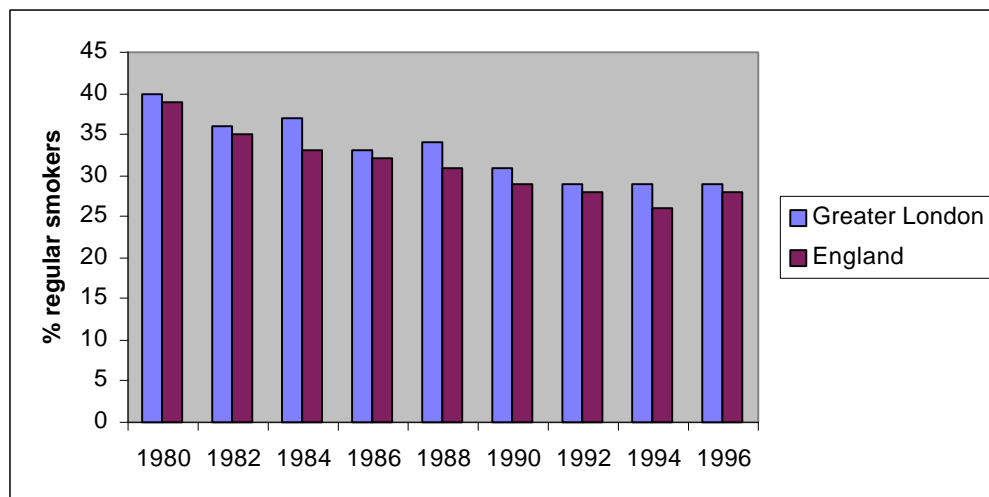
There is therefore a shortage of health promotion and health policy studies eligible for systematic review, and many seminal evaluations of health promotion projects and programmes would be ineligible for inclusion.

The evaluations of tobacco control actions suitable for city-wide implementation are particularly rare, and the search used a wide range of techniques, and adopted a low threshold for inclusion to include as much evidence as possible in the review.

4. EPIDEMIOLOGY

29% of adults in Greater London smoke, about the same as the proportion of smokers in England as a whole.³ Smoking in London has been falling steadily for two decades, as it has in the rest of the country, and Figure 1 shows trends for Greater London and England since 1980. This means just over a million men and just under a million women living in London are smokers, not including commuters and tourists.

Figure 1: Trends in adult smoking prevalence, England and Greater London 1980 - 1996



Persons aged 16 and over. Source: GHS 1996³

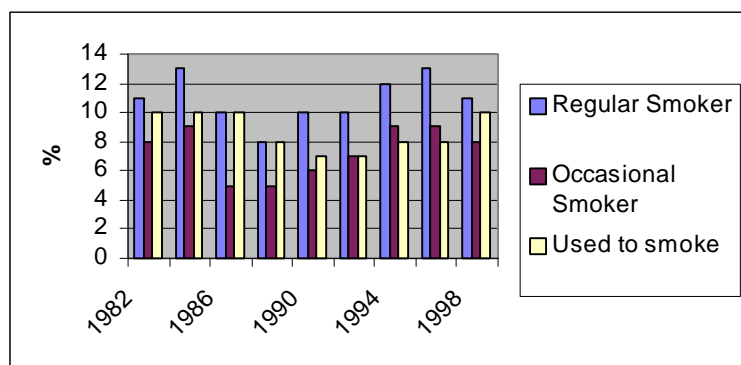
Priority groups

Cigarette smoking varies by age, sex and other socio-economic factors, and two of the priority groups in *Smoking Kills*¹ have been identified partly by not sharing the falling trend seen in the general adult population in Greater London and the rest of England.

Secondary school age children

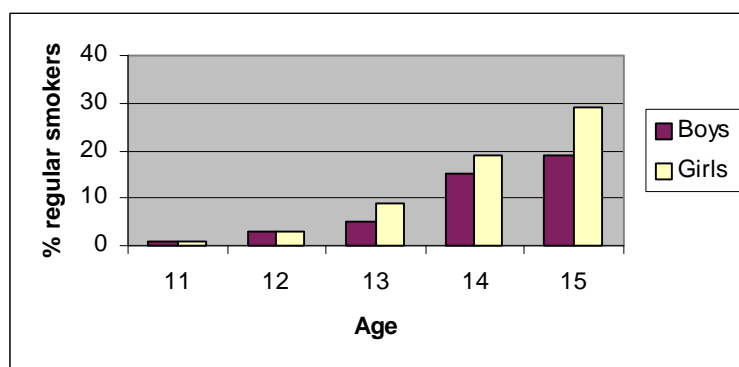
Children's smoking has been rising since 1988 in England, for both boys and girls. In 1996 25% of girls and 19% of boys in secondary school were regular or occasional smokers (Figure 2). By the age of 16, girls' smoking prevalence is higher than that for adult women (Figure 3).⁴

Figure 2: Trends in smoking among secondary school children England 1982-1998



Secondary school children (11-15) source: ONS 1998⁴

Figure 3: School children's smoking by age and sex England 1998



Secondary school children (11-15) source: ONS 1998⁴

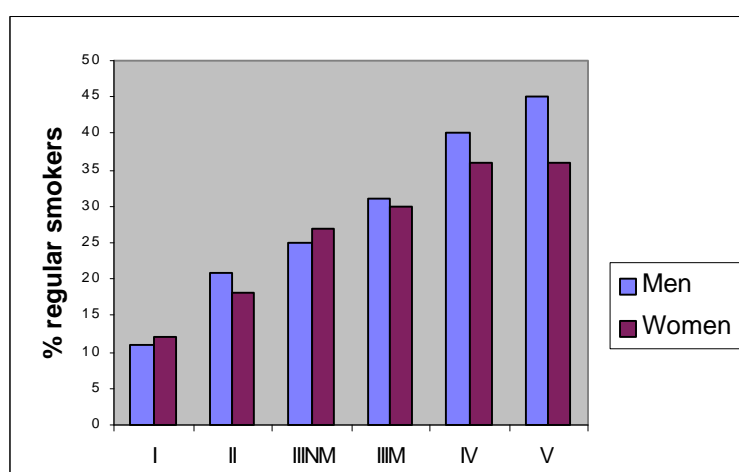
Greater London has similar levels of children's smoking to those in England as a whole.

Socio-economic status

Smoking prevalence has fallen in all occupational social classes since the 1960s. However the most privileged were the quickest to give up and gave up in the greatest numbers.³ Figure 4 shows a strong relationship between smoking prevalence and socio-economic status measured by occupational classification. For the lowest income quarter, smoking did not decline at all during the last two decades, and smoking is closely and independently related to specific features of disadvantage such as receipt of means tested benefit, and lone parenthood.⁵ For example 62% of lone mothers in the lowest income quarter smoke,⁵ about twice the prevalence of women under 49 in the general population.³ Figure 4, therefore, underestimates the social gradient in smoking prevalence, since it does not include claimants, or distinguish between other features of disadvantage.

Smoking Kills proposes prioritising the most disadvantaged in the provision of help to those who want to give up. About two thirds of smokers would like to give up, and this proportion does not differ strongly between occupational classes, or between other indicators of socio-economic status such as whether people own or rent their home.⁶

Figure 4: Smoking prevalence and occupational group, England 1996



Persons aged 16 and over Source: GHS 1996³

I: Professional; II: Employers & managers; IIINM: Intermediate/junior non-manual; IIIM: Skilled manual; IV: Semi-skilled manual; V: Unskilled manual

The socio-economic gradient found in adult smoking is much weaker, though still evident, among secondary school children,⁴ suggesting that the ability to give up smoking, or not to take it up, in young adulthood, is the biggest determinant of the socio-economic gradient in cigarette smoking.

Pregnant women who smoke

A third of pregnant women smoked before their pregnancy. The social gradient and the high smoking level of lone mothers is reflected among pregnant women, and nearly two thirds of pregnant women without partners smoked before the start of their pregnancy.⁷ A third of pregnant smokers give up during pregnancy, (a quarter of pregnant women without partners). 105,000 babies are born in London each year,⁸ and about 79,000 London women, including 26,000 who smoked before the start of their pregnancy are likely to be pregnant at any one time.

5. THE INTERVENTIONS AVAILABLE

Table 5 to Table 9 in the Appendix list actions to support the government strategy *Smoking Kills*, with notes on local competence in London, and on whether they have been included in city-wide programmes. The list has been expanded slightly using the expert task force report from the National Heart Forum, *Looking to the future*,⁹ and interventions used by the city-wide programmes.

Interventions which fall within London-wide competency or could benefit from London-wide action, judged by their inclusion in city wide programmes, have been identified as appropriate for evidence review.

The following city-wide programmes were identified:

- *SmokeFree Birmingham*. Information was obtained from a report to health authority with 6 Appendices and an extensive conversation with the director and evaluation lead. SmokeFree Birmingham has been running since 1997. It is funded mainly by Birmingham Health Authority, which is coterminous with Birmingham City Council.¹⁰
- *Glasgow 2000*. Information was obtained from evaluation reports for internal use and a conversation with project staff. Glasgow 2000 has been running since the early 1980s. It is mainly funded by Glasgow Health Board which is coterminous with the local authority.¹¹
- *Stockholm Comprehensive Tobacco Prevention*. Information was obtained from a brief note supplied by director, and email exchange. Stockholm's programme is led by the city authority which is responsible for health and municipal services. Sweden has a broad national policy approach to tobacco control, and is the only country which has achieved the WHO target of less than 20% adult smoking.¹²
- *Sydney Tobacco Control Plan*. Plan obtained. The Tobacco Control Plan was adopted in 1996 and is led by the health authority for central Sydney.¹³

All of these programmes deal with fewer statutory bodies than a London-wide programme would. They cover areas that include only one health authority, and obtaining funding from the health authority is simpler (though not automatic, and Sydney's key actors have written an account of the process of obtaining funding).¹⁴ In the future Birmingham will have to advocate to several PGCs for a Birmingham-wide smoke-free programme. Another consequence of working under a single health authority is that they provide services that might still be provided by London's health promotion units if there were a London-wide strategy. The co-ordinator of London's tobacco alliance, CHAT, was also interviewed and advised on London's situation.

Criteria for including interventions in the review of evidence for a London wide programme were as follows:

- economies of scale;
- co-ordination and consistency;
- city-wide population forms a natural target group for the intervention (especially on the case of dispersed minority populations, and those which cross London regularly such as commuters and those who use central London facilities);
- action comes within competency of city-wide authority.

These criteria were applied to the interventions in Table 5 to Table 9. Evidence for interventions selected using these criteria was reviewed.

Interventions included in rapid review

Interventions fell into groups according to methods used and lead responsibility as follows:[need to link to headings of Tables]

- *Changing attitudes* through mass communications, events, and advocacy to opinion formers. There are economies of scale in London-wide implementation of these interventions, and benefits from a consistent message. The reach of press and television, London's dispersed minorities and the large numbers of Londoners who travel within London regularly mean that there is a natural London-wide target group for many of these interventions. Interventions of this type were found in every area for action identified in *Smoking Kills*, and the evidence review treated these interventions together as a 'method' review.

- *London-wide facilitation and co-ordination* to develop or provide services and resources where there is no lead agency at present, but where London wide interventions could support and enhance the work of other agencies. These interventions have been reviewed within the method review on changing attitudes, and under the *Smoking Kills* headings, Cessation, Clean Air, Young People. They might include publicity, development of resources and facilitation of sharing of good practice and training in all these areas.
- *Provision of certain London-wide services* including development of training, pilot projects or resources where the NHS has a clear lead responsibility. There is scope for economies of scale through central provision, or for co-ordination by a London-wide programme. This is especially so in the development of materials and services for some minorities, and in the provision of centrally located services for people who live in all parts of London. Organisational development within health authorities and within a London-wide programme would be needed for cross-health-authority interventions. These interventions are reviewed within the method review on changing attitudes, and under the *Smoking Kills* headings, Cessation, Clean Air, Young People.
- *Interventions which are clearly the responsibility of statutory agencies, and where there is no added value in London-wide provision, co-ordination or facilitation.* These may have been undertaken by other city wide programmes in their capacity as local health promotion service providers. The effectiveness of these interventions has not been reviewed.

The review also included 'whole-programme' evaluations and the added value of inter-sectoral collaboration.

6. EFFECTIVENESS OF INTERVENTIONS

Comprehensive tobacco strategies and interagency collaboration

No reviews were found of the added value of multi-sectoral or interagency collaboration, or of the benefits of comprehensive programmes. Expert consensus has repeatedly asserted the benefits of a concerted approach.^{2 15} Both Glasgow 2000 and Smoke Free Birmingham have whole programme reviews in preparation, to be published shortly. WHO Europe includes city-wide action for tobacco control in its Smoke-free Europe programme, and a meeting carrying this work forward is being held in Belfast in October 1999.¹⁶ The NHS Centre for Reviews and Dissemination is preparing a review on community interventions for tobacco control.

Changing attitudes

Table 1 summarises reviews of mass media interventions, including paid and unpaid newspaper coverage, poster and broadcast media campaigns. Systematic evidence reviews,^{17 18} and expert and practitioner consensus^{9 19 20} support an important role at local level for paid and unpaid mass communications including events such as No Smoking Day. Mass communications, in support of other policies, appear to be best organised at a sub-national level.²⁰

The impact of mass communications includes both changes to smoking behaviour, and changing the climate of opinion in favour of actions such as maintaining clean air free from environmental tobacco smoke and ensuring that children cannot buy cigarettes. They can also enhance the uptake of cessation services such as Quitline and targeted programmes. Smoke-free Birmingham is involved in extensive awareness-raising activity, and process outcomes include achieving 40% of press coverage across the country mentioning tobacco control alliances, and a regional rate of calls to Quitline considerably above the national rate.²¹

Smoking Cessation

Table 2 summarises evidence on support for NHS cessation activities which could be provided at a London wide level with economies of scale. Training enhances the effectiveness of a range of health care professionals in providing opportunistic and dedicated smoking cessation advice.^{22 23} However, there is no evidence at present that the provision of printed materials to support professional advice enhances its effectiveness.²⁴

Two systematic reviews have demonstrated benefits of smoking interventions targeted to pregnant women,^{25 26} but these did not look separately at the contribution of distinct elements such as supporting materials or efforts to increase uptake which might be contributed by a city-wide programme.

Clean air

Rapid review found no studies which evaluate interventions appropriate for a London-wide programme to support local action for clean air. However, surveys suggest scope for action, and descriptive studies from the US and Canada are relevant despite different legislative situations. The experience of existing city-wide tobacco control initiatives can indicate where a London wide approach could help.

Support for restrictions on smoking in workplaces and public places including shops, pubs and restaurants is over 90% in the UK, and for most settings (hospitals, cinemas, transport, shops) over 70% of people support a complete ban. In restaurants, pubs and workplaces about half of those asked favour restrictions on smoking which allow smoking in a separate area.²⁷ Practice in all settings lags behind public opinion – 63% of shops, 71% of health premises and 14% of pubs had a policy which provided for some smoke-free space and was effectively applied in a 1996 survey for the Department of the Environment.²⁸

In the US and Canada, where cities can legislate to control smoking in public places, both likelihood of legislation being enacted^{29 30} and the success of its implementation,^{30 31} depends on mobilising community support for legislation – bringing privately held opinions, like those expressed to researchers in UK surveys, into the public domain.

The findings of these descriptive studies are summarised in Table 3. Taken together they suggested that building a high profile for a policy to make more places smoke free, which already has a high level of public support, facilitates its implementation.

Young people

Enforcement of laws on tobacco sales to children has a local effect on children's smoking prevalence but probably at high direct cost. There is, however, great added value in combining monitoring and enforcement with high profile prosecution and retailer education.^{9 10 32 33} In London, action could be concerted between health promotion units and trading standards officers, co-ordinated across London and potentiated by centrally generated unpaid news coverage. A licensed retailer scheme, involving proof-of-age cards and tobacco industry co-operation has been suggested to develop the existing law.^{9 34}

No reviews of actions applicable at a London-wide level to support school tobacco education or school tobacco policies were found by rapid review.

Table 1 to Table 4: Review of evidence*Table 1: Reviews of interventions to change attitudes to tobacco control*

Author(s), Study Title, Date	Interventions	Target group	Method	Conclusions	Costs effectiveness	Notes
Sowden & Arblaster. Mass media interventions for preventing smoking among young people 1998 ¹⁷	mass media campaigns intended to reach large numbers of people and which are not dependent on person to person contact	Young people	electronic and hand search, references notified by experts; included controlled and before-after trials	Some evidence of effectiveness in preventing uptake	Not reported	
Reid D. How effective is health education via mass communications 1996. ¹⁹	Mass communications – any form of communication with the public which does not depend on person-to-person contact, usually carried out through the mass media.'	Various	Non-systematic overview, no method given	Probably more effective than interpersonal communication with large populations. TV the most equitable.	Unpaid publicity probably the most cost effective, but limited scope	Local, city-based initiatives more likely to be effective than national campaigns, especially as the integration of paid advertising with both unpaid publicity and interpersonal education is more readily achieved with local campaigns
Redman S et al. The role of mass media in changing health related behaviour. 1990 ¹⁸	Mass media to modify health risk behaviour	Various	computer literature search for evaluative studies with baseline measures, control groups, validated outcome measures and representative sampling.	Effective in combination with a community component in an agenda setting role, not effective alone	Not investigated	Need for improved evaluation methods [which have occurred since this review]
Reid et al. ²⁰ Choosing the most effective health promotion options for reducing a nation's smoking prevalence 1992	Paid mass media advertising	Various	Review of a range of interventions for change in behaviour, impact on influence on public opinion, with consideration of acceptability and cost	A leading intervention with a probable direct effect on smokers and the capacity both to enhance the value of community based interventions and to drive all other aspects of a total communications program. Possible 5% success rate.	England-wide campaign might cost £10m annually (1990 prices)	Local advertising probably preferable to national campaigns on cost grounds, as part of a national strategy

Author(s), Study Title, Date	Interventions	Target group	Method	Conclusions	Costs effectiveness	Notes
	Unpaid publicity in the media (news and human interest stories, coverage of scientific	Individual smokers and opinion formers/policy makers	Review of a range of interventions for change in behaviour, impact on influence on public opinion, with consideration of acceptability and cost	Affects both smoking behaviour and public opinion, and hence public policy. Reaches large numbers quickly	Relatively modest cost	Needs development of appropriate skills
National Heart Forum. <i>Looking to the Future 1999</i> ⁹	Paid and unpaid mass communications	Preventing teenage smoking	Expert task group consensus	mixed results	High direct costs	
	Mass communications Cessation campaigns	Quitters		Can enhance natural quit rate by 5%	High direct costs, high reach	
	Mass communications – media advocacy and unpaid publicity	Smokers, opinion formers		Linked with major declines in prevalence, major effect is on public opinion	Direct costs in terms of professional time can be high, generally thought to be cost effective.	Enhances effect of other policies

Table 2: Reviews of interventions to support cessation activities

Author(s), Study Title, Date	Interventions	Target group	Method	Conclusions	Costs effectiveness	Notes
Freemantle et al Printed educational materials to improve the behaviour of health care professionals and patient outcomes ²⁴	Printed materials to support physician advice	various	structured electronic search, and references identified by experts; includes controlled and before-after studies	Small additional effect to physician advice alone More interactive interventions with audio and feedback may increase impact, though number not clear	Too little cost data in reviewed studies to make a conclusion	Negative results could be due to poor reporting
Lancaster et al . Training health professionals in smoking cessation. 1998 ²²	Training health professionals in smoking cessation.	quitters	Structured search for randomised controlled trials with 6-month follow up	Significant improvement in professional practice, modest increase in cessation above that from untrained professionals	Not reported	

Author(s), Study Title, Date	Interventions	Target group	Method	Conclusions	Costs effectiveness	Notes
Sinclair et al Training pharmacists and pharmacy assistants in the stage-of-change model of smoking cessation: 1998 ²³	Training for pharmacy staff in smoking cessation support	quitters	Randomised controlled trial	Customers of trained staff more likely to quit, and improved process/quality outcomes	Not reported	

Table 3: Descriptive studies relevant to ensuring clean air

Author(s), Study Title, Date	Interventions	Study group	Method	Findings
Owen L. Passive smoking and smoking policies 1995 ²⁷	Smoke-free policies in several settings open to public	General public	Cross-sectional population survey of preferences and perceptions (part of larger health and lifestyles survey)	Overwhelming (>90%) public support for smoking restrictions in premises open to public and workplaces with high support for total bans in some areas
NOP Social and Political. <i>Smoking in Public Places. 2nd Survey report. 1996.</i> ²⁸	Smoke-free policies in several settings open to public	Settings for smoking policies	Cross sectional survey of prevalence of effective surveys	Only 2 categories of establishment – formal education and health, come close to the [UK] Government's target [in 1996] that 80% of establishments should have effective smoking policies.
Rigotti NA et al. No Smoking laws in the United States. 1991 ²⁹	State and city legislation to restrict smoking in public places and workplaces	US cities with populations greater than 25,000	Cross-sectional survey of prevalence of no-smoking legislation	Laws were more common in larger cities, Western cities, and states with fewer adult smokers. Laws were less common in tobacco-producing states and in the South
Rigotti NA, et al. Retail stores' compliance with a city no-smoking law. 1993 ³¹	City no smoking law	Retail stores	Cross sectional survey of compliance with laws	Compliance with no-smoking law is not guaranteed. In retail stores, compliance may be improved if stores adopt no-smoking policies, post signs, and teach employees to enforce the law.

Table 4: Reviews of interventions to reduce smoking among young people

Author(s), Study Title, Date	Interventions	Target group	Method	Conclusions	Costs effectiveness	Notes
Central Sydney Area Health Service <i>Tobacco Control Plan 1996</i> ¹³	Enforcement of law on sales to minors combining monitoring of retailer compliance with high profile prosecutions and retailer education	Sales to young people	Rapid review of evidence using explicit evidence hierarchy criteria for city-wide tobacco control programme	A combination of all three strategies (monitoring, high profile enforcement and retailer education) is necessary to reduce uptake of regular smoking among adolescents	Not reported: - 1 FTE enforcement officer and 1.4 FTE health promotion officer sought for Sydney, (partly from existing resources) Central Sydney pop c500,000	needs multi-sectoral collaboration.
Reid D et al . Reducing the prevalence of smoking in youth in Western countries. 1995 ³²	Legislation to restrict sales to minors	Adolescents	Review of strategies for national application, against criteria - efficacy, cost to health sector, reach and impact – no explicit inclusion criteria	Delay in uptake is the most that can be achieved through this means. Nevertheless, sales to teenagers should continue to be restricted to the contrary.	\$35 per annual retailer compliance check, 1993	
National Heart Forum. <i>Looking to the Future 1999</i> ⁹	'Vigorous local activity' to stop sales	Young people	Review of a range of interventions for change in behaviour, impact on influence on public opinion, with consideration of acceptability and cost	Can reduce sales locally	Direct costs 'considerable'	Popular with politicians,. Licensed retailer scheme funded by tobacco industry?
Preventing tobacco use among young people – a report of the Surgeon General ³³	Enforcement of age-at sale policies by public officials and community members	Young people	Review of interventions to prevent young people's smoking with explicit hierarchy of evidence	Necessary to prevent minors' access to tobacco		

7. GAPS IN THE KNOWLEDGE BASE

- Whole programme evaluations
- Understanding successful cross sectoral multi agency partnership
- Stimulation and dissemination of evaluations of local tobacco control actions. Evaluations should be designed to consider the transferability of the actions, and dissemination should be international.
- Validated proxy measures of mass communications, to develop process measures of changes in prevalence or attitude.
- Development of communication and media skills in public health and health promotion specialists involved in tobacco control
- Effectiveness of cessation services for special populations including the best settings, resources and media for particular sub-groups.

8. POLICY IMPLICATIONS FOR LONDON

Guiding principles

- Tackling tobacco is essential to London's health
- Tobacco control needs concerted action across sectors
- The roles of the NHS, Government and some enforcing agencies are clear in *Smoking Kills*, and other agencies have important though less defined roles.
- Some interventions within *Smoking Kills*, and some supporting interventions, are backed by strong evidence, and others have a considerable track record.
- London has a great opportunity, as a very large population with a strong city identity, to undertake a city wide programme. London-wide action can increase impact by providing a consistent and sustained message across borough and health authority boundaries.
- Innovation is needed to reduce smoking prevalence in the *Smoking Kills* priority groups. Allowance must be made for innovations which go beyond the existing evidence base.

Priority actions – timescale

Short term - first year

Concentration on actions which could not be undertaken by partner organisations:

- Development of cross-sectoral multi-agency partnership
- Development of London-wide mass communications and events with built in evaluation
- Exploring international collaboration to share evaluations of local and city-wide interventions, possibly as an activity of the regional observatory soon to be established.

Medium term - year 2

Builds exchange of experience between partners, facilitating and co-ordination

- Facilitation of co-operation between agencies and across London, development of co-ordinated action and sharing of good practice by health authorities, local authorities and the voluntary sector

Longer term - year 3 and beyond

Builds pooling of resources for joint service provision for special groups

- Service provision for London-wide target groups and development of pilot projects (needs organisational development within programme and partner agencies.)

Priority actions - Changing attitudes

Action under Smoking Kills

The government has recently contracted for a major national advertising campaign targeted to priority groups, and looks to local statutory and voluntary bodies to enhance the impact of national publicity through local work.

Effective London-wide action

The travelling that Londoners do for work and leisure make London a natural target group for sub-national paid and unpaid mass media and events. Most of the Carlton TV area and BBC's South East Region is made up of London. The imaginative use of council and NHS property in Birmingham's campaigns, and their sustained and consistent use of the local evening paper could be adapted for London. London's dispersed minority populations can be reached through minority press, cultural and religious venues and radio stations.

Priority actions - Smoking Cessation

Action under Smoking Kills

Smoking Kills brings considerably enhanced cessation services, for the general population, for the most deprived (an initiative starting in Health Action Zones, which will be applied more widely next year) and for pregnant women. Health Authorities have a responsibility for introducing local cessation plans through Health Improvement Programmes. There is a strong role for primary health care and community services including pharmacies. Where possible the impact of NHS professionals will be enhanced by training, and the use of NRT will be encouraged for groups where its use is indicated, with a week's free NRT participants in the schemes for cessation services for the most deprived.

Effective London-wide action

Health authorities have responsibility for training, but there may be scope for collaboration between health authorities across London, and possibly for employees of voluntary and other statutory agencies, in the provision of training, particularly targeted training for special populations.

Publicising cessation services (see Changing Attitudes above) could be done London-wide, so that people were made aware on their way to work that support for cessation was available through local health services, through Quitline and possibly through workplace services too.

Priority actions - Clean air

Action under Smoking Kills

Smoking Kills enhances action to keep workplaces, pubs, restaurants, entertainment facilities and public buildings free of environmental tobacco smoke or to restrict it to particular areas so that people can opt for a smoke free environment.

Consultation on a new Approved Code of Practice for workplaces closed on 29 October. The Code will be enforced by the Health and Safety Executive and by health and safety officers of local authorities.

The Public Places Charter, a voluntary charter endorsed by trade associations for pubs and restaurants has recently come into force, to be overseen by the trade bodies who will report to the Department of Health.

Effective London-wide action

London-wide action would support the role of existing lead enforcing bodies. The enforcement of smoking policies in public places and workplaces falls on local authority and HSE officers who have a heavy load of statutory responsibilities. Their work could be facilitated by a climate of opinion favourable to their efforts. A powerful application of mass communications, therefore, could be the raising of awareness of the workplace Approved Code of Practice and the Public Places Charter.

Employees and people using pubs, public buildings and restaurants are particularly likely to cross health authority and borough boundaries, and, with the support of enforcing bodies and the professional bodies of appropriate enforcement officers, this would be a valuable field for London-wide action. Such actions could include:

- posters on sites donated by statutory authorities
- smoke-free eating and entertainment guides for tourists and Londoners, perhaps with the collaboration of the tourists board, chambers of commerce, trades associations or listings magazines
- generation of local news coverage around monitoring and enforcement of compliance

This kind of publicity will harness the public support which is known to exist for policies which ensure clean air and protection from environmental tobacco smoke. Consultancy on smoke free policies could generate income for the programme while providing a consistent message and promoting best practice.

Priority actions - Young people

Action under Smoking Kills

Tobacco advertising in shops is to be restricted further, and a new enforcement protocol will strengthen existing legislation restricting sales to minors. Trading standards officers have lead local responsibility, but it is up to the Boroughs how active they are in monitoring the law. Prosecution of offenders is encouraged in *Smoking Kills*.

The government is encouraging producers of age-restricted goods to collaborate on a national proof-of-age card scheme. There will be a teenage advertising campaign, and schools will provide smoking education, either separately or as part of comprehensive health education.

Effective London-wide action

A London wide programme could generate publicity around monitoring and enforcement of the law on tobacco sales to minors, involving the Boroughs and LACOTS. In the longer term it could facilitate dissemination of models of successful school education and school no smoking policies

APPENDIX: INTERVENTIONS FOR WHICH EVIDENCE WAS REVIEWED

Table 5 to Table 9: The interventions available

Table 5: Young people. Interventions to support Smoking Kills, and factors relevant to their inclusion in a London-wide programme

Intervention	London competence role	Included in other city programmes?	Role for London for which evidence is reviewed
Enforcement of under age sales legislation	Trading standards officer (London Borough) enforcement	Birmingham- support for trading standards officers Sydney - enforcement combined with high profile prosecution and retailer education; enforcement of compliance with restrictions of advertisements in shops; project for non-English speaking retailers on sales law	London-wide facilitation/co-ordination
Proof of age	Local schemes possible - national scheme likely?		London-wide facilitation/co-ordination
School tobacco education	Education Authorities, Schools	Glasgow - development support	London-wide facilitation/co-ordination
School no smoking policy	Education Authorities, Schools	Glasgow - development support	London-wide facilitation/co-ordination
Out of school activity	Statutory and voluntary agencies	Birmingham, Glasgow - clubs	None
Targeted mass communications	Statutory and voluntary agencies	All Sydney - focus on youth of non English speaking background	Review evidence in combination with other communications interventions
Development of educational materials	Statutory and voluntary agencies	Birmingham, Glasgow - special groups	Economies of scale/special dispersed populations - London-wide facilitation/co-ordination or provision

Table 6: Adults, particularly the most disadvantaged, who want to give up. Interventions to support Smoking Kills, and factors relevant to their inclusion in a London-wide programme

Intervention	London competence role	Included in other city programmes?	Role for London for which evidence is reviewed
Targeted local cessation programmes	HA Comprehensive plans in Health Improvement Programmes		None

Intervention	London competence role	Included in other city programmes?	Role for London for which evidence is reviewed
Opportunistic cessation advice in primary health care	HAs/PCGs	Stockholm - computer system 'Dr Smoke-Free' to support primary physicians, with multi-lingual support	London-wide facilitation/co-ordination
Opportunistic cessation advice in community pharmacies	HAs	Stockholm - multi-lingual resources distributed through pharmacies	Development of support resources - economies of scale/special dispersed populations - London-wide facilitation/co-ordination or provision
Opportunistic cessation advice in secondary care	HAs, Trusts	Birmingham - advice to trusts Stockholm has in the past offered in-patient smoking cessation	Development of support resources - economies of scale/special dispersed populations - London-wide facilitation/co-ordination or provision
Cessation groups	HAs	Birmingham - city centre group, pilot models for special groups Stockholm - City centre group Sydney - limited number for highly dependent	London-wide facilitation/co-ordination
Training for health professionals	HAs	Birmingham - for health visitors etc emphasising needs of poorest smokers; for hospital staff Glasgow Stockholm - included training for dental surgery staff Sydney -- including promoting cessation among health workers	Economies of scale/special dispersed populations - London-wide facilitation/co-ordination or provision
Phoneline with taped information	HAs – NHS direct	Birmingham - multi-lingual Freefone Stockholm - 24 hr Freefone with option of faxed information	London-wide facilitation/co-ordination
Promoting cessation services and Quitlines	All agencies	All Birmingham - research to enhance calls to Quitline	Review evidence in combination with other communications interventions
Seasonal Events (No smoking day, new year's day, Ramadan)	All agencies	Glasgow - No Smoking Day co-ordination, sponsored events Birmingham - includes TV cessation programme on No-Smoking Day, Ramadan, sponsored comedy tour and sports and social events, hospital and university open days. Campaigns supported by briefing for professionals	Review evidence in combination with other communications interventions

Intervention	London competence role	Included in other city programmes?	Role for London for which evidence is reviewed
Developing resources	All agencies	Glasgow - materials including materials for special groups	Development of support resources - economies of scale/special dispersed populations - London-wide facilitation/co-ordination or provision

Table 7: Pregnant women. Interventions to support Smoking Kills, and factors relevant to their inclusion in a London-wide programme

Intervention	London competence role	Included in other city programmes?	Role for London for which evidence is reviewed
Targeted smoking prevention groups	HAS	Glasgow	Review evidence for awareness raising in combination with other communications interventions
Opportunistic advice from health services	All NHS		Training - Economies of scale/special dispersed populations - London-wide facilitation/co-ordination or provision

Table 8: Action for everyone. Interventions to support Smoking Kills, and factors relevant to their inclusion in a London-wide programme

Intervention	London competence role	Included in other city programmes?	Role for London for which evidence is reviewed
Ending tobacco advertising	Government, All agencies can monitor		Review evidence for awareness raising in combination with other communications interventions
Public education – changing attitudes	All agencies	All - various strategies including paid and unpaid media and advocacy to opinion formers, hosting conferences, high profile interagency campaign	Review evidence for awareness raising in combination with other communications interventions
Supporting high prices – anti-smuggling drive	Government, Police to support Customs & Excise		Review evidence for awareness raising in combination with other communications interventions

Table 9: Clean air. Interventions to support Smoking Kills, and factors relevant to their inclusion in a London-wide programme

Intervention	London competence role	Included in other city programmes?	Role for London for which evidence is reviewed
Smoking in public places	<i>Smoking Kills</i> proposes local role for health promotion units in monitoring Charter	<p>City-level legislation in US and Canada</p> <p>Birmingham and Glasgow - consultancy, developing materials and awareness</p> <p>Birmingham and Glasgow - schemes to encourage children to make their homes smoke-free</p> <p>Sydney - support for householders and especially carers who want to make their homes smoke free</p> <p>Birmingham - <i>Guide to smoke-free Birmingham</i> distributed to C2DE areas: Sydney - support for and monitoring of smoke-free eating places</p> <p>Birmingham 'No Butts Bins' city centre initiative</p>	Review evidence for awareness raising in combination with other communications interventions
Smoking at work		<p>Birmingham, Glasgow - consultancy</p> <p>Stockholm - within national scheme including health benefits and financial incentives to employers</p> <p>Sydney - monitoring and advice</p>	<p>Review evidence for awareness raising in combination with other communications interventions</p> <p>London-wide facilitation/co-ordination or provision</p>

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