

Young people, smoking and health

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NCB promotes the voices, interests and well-being of all children and young people across every aspect of their lives.

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Introduction

High levels of smoking among young people give rise to considerable current concern and constitute an important public health issue. The main reasons for this concern include the following:

- It is estimated that 450 young people take up smoking every day in the UK (Royal College of Physicians 1992).
- Around 82 per cent of adult smokers started smoking as teenagers (Department of Health 1998a).
- The earlier the age that smoking starts, the longer it continues (Chen and Millar 1998).
- There has been no evident reduction in the numbers of young people smoking in recent years. Although smoking prevalence among teenagers hit a peak of 13 per cent in 1996, it has remained stable at around 10 per cent since 2000 (ASH 2004a).
- Smoking is a proven health risk and it can kill (Pearl 1938; US Department of Health, Education and Welfare 1964; Peto and others 1992).
- Smoking is addictive (Andrews 2004).
- There are possible links between smoking and the use of other more serious and illegal drugs (MORI 1990). Although the nature of associations is unclear, it may well be that a reduction in smoking behaviour has an impact on other forms of substance misuse. As evidence seems to suggest that early tobacco smoking is linked to later cannabis and other substance misuse, delaying smoking may lead to less harmful involvement with other substances.
- The friends, family and peers of young smokers are likely to be exposed to the effects of passive smoking, and some of these are likely to be children. Although young people alone are not responsible, ASH (2002a) reports that 17,000 children under the age of five are admitted to hospital every year in the UK because of the effects of passive smoking.
- Young mothers who smoke may be affecting the health of their babies and infants: children are particularly susceptible because their bronchial tubes are smaller, their immune systems less developed, and their airways smaller than adults'.

As the statistics indicate, smoking interventions to date have been largely ineffective in discouraging young people from taking up smoking or encouraging them to stop once they have started. There are, nonetheless, some messages from research and practice, and this review examines this evidence to help to identify the future role that the National Children's Bureau (NCB) might have in this field. The focus of this review is fourfold. First, it sets the context by looking at national activity and guidance in this area. Second, it outlines factors shown to be associated with smoking behaviour among young people to provide pointers to the likely essential features of successful intervention programmes. Third, it examines past and present prevention and

cessation programmes to see what lessons have been learned, and to extract any instances of good or effective practice. And fourth, it summarises the messages and key issues to help to establish the future direction that NCB might wish to take.

1. National activity and guidance

There are two main strands to national activity and guidance in relation to smoking and young people. The first addresses smoking behaviour by young people and the second relates to the impact of passive smoking on them. These issues are, nonetheless, related to some degree in that (as outlined below) exposure to passive smoking can in itself be a risk factor, increasing susceptibility to smoking behaviour.

***Smoking Kills* – A White Paper on tobacco**

In 1998, the government set targets to reduce the prevalence of smoking among young people aged 11 to 15 years from a baseline of 13 per cent in 1996; to 11 per cent by 2005; and 9 per cent or less by 2010. In the White Paper, *Smoking Kills* (Department of Health 1998a), it outlined the need for action to counteract the growth in numbers of children starting to smoke. This action comprised introducing legislation to ban advertisements on billboards, minimise advertisements for tobacco in shops, control the siting of cigarette vending machines, clamp down on underage sales; and putting forward proposals to introduce a proof-of-age card. The government's pledge to spend over £100 million on its anti-smoking programme includes £50 million to be used on an anti-smoking marketing campaign and £60 million to fund an NHS programme to help smokers give up. The latter includes GP referrals for counselling, the prioritising of pregnant women, and free nicotine replacement therapy for one week. An extra £35 million will be used to help combat tobacco smuggling and support the World Health Organization's (WHO's) anti-smoking at work campaign. A 'clean air' charter calls for smoking and non-smoking areas in pubs and restaurants; a badge scheme for participating venues; national targets for smoke-free public places; and a Health and Safety Commission consultation on protecting employees from smoke at work.

Coleman and others (2000) looked at how recommendations in this White Paper were implemented by local cessation services. It emerged that while young people were highlighted as a priority group, most services did not target them. The reasons given included the specification within the White Paper that services should be available primarily to adult smokers. Also, local services were given the scope to identify priority groups and tended to focus on those with smoking-related illnesses. The report also found a distinct lack of experience among cessation services coordinators in the running of clinical services in general and smoking cessation services in particular. Difficulty in recruiting smoking cessation advisors was reported.

The Children Act 2004 and Every Child Matters

The Children Act 2004 spells out the required infrastructure for local authorities to manage children and youth services, and highlights that all bodies must work together. It also provides the legal underpinning for *Every*

Child Matters: Change for children (DfES 2004a). The legislation itself makes no direct reference to smoking, but service delivery measures can be related to ensuring healthy outcomes for children and young people.

Every Child Matters: Change for children sets out five key outcomes for children that provide a focus for services. Smoking is mentioned only briefly under the 'Being Healthy' outcome. Policy challenges mentioned in the paper, such as early intervention and better prevention, can be related to smoking initiatives among children and young people – although there is no specific mention of smoking prevalence under these headings.

Every Child Matters: Change for children. Young people and drugs (DfES 2005) is a subsequent publication to support the delivery of services based on *Every Child Matters* as well as the updated National Drug Strategy (which applies only to illegal drugs). While there is no specific mention of tobacco smoking, this document highlights the need for an integrated approach to a reduction in drug use among children and young people. There is a special focus on prevention and early intervention among those most at risk, such as children and young people in care and custody. According to this document, core children's services such as schools must take a leading role in delivering drug education. There is also a call for drug education and information to be easily accessible.

National Service Framework for Children, Young People and Maternity Services

Young people and smoking are addressed from two perspectives within this national service framework for children's services (Department of Health 2004a). The first perspective relates to Standard 1 of the framework. This stipulates that the health and well-being of all children and young people should be promoted through a coordinated programme of action, including prevention and early intervention wherever possible. This is to be led by the NHS in partnership with local authorities. Targets are to be met through multi-agency health promotion of information; and through services encouraging children and young people to take responsibility for their actions and make informed choices about healthy lifestyles.

The second perspective relates to Standard 4, which builds on the first standard. It requires health promotion for young people to be targeted to meet their needs and, in particular, to reduce teenage pregnancy, smoking, substance abuse, sexually transmitted infections and suicide. It also stipulates that young people should be actively involved in planning and implementing health promotion services and initiatives.

Department of Health's *Priorities and Planning Framework 2003–2006*

Smoking is mentioned within the Department of Health's *Priorities and Planning Framework 2003–2006* (Department of Health 2002) under the cancer priority. It is stipulated that there should be an aim to:

reduce the rate of smoking, contributing to the national target of:
reducing the rate in manual groups from 32% in 1998 to 26% by 2010;
800,000 smokers from all groups successfully quitting at the 4 week stage by 2006.

There is also mention of reducing smoking rates for pregnant women. There is, however, even under the 'Life chances for children' priority, no mention of reducing smoking prevalence among young people.

***Choosing Health: Making healthier choices easier* – Public Health White Paper**

Choosing Health (Department of Health 2004b) emphasises the need to encourage people to make healthy choices, and not smoking is addressed as an important part of this. Section 3 is entitled 'Children and young people – starting on the right path' and suggests that ways to reduce smoking among young people include increasing the role of school nurses; involving healthy schools more (discussed below); reiterating the role of ID cards and advertising, as mentioned in the 1998 White Paper; and following examples of best practice such as in a youth magazine in Manchester. There is also a strong emphasis on the need to help pregnant women stop smoking and, through health visitors, to ensure that parents are aware of the health risks that smoking brings to both themselves and their children.

Delivering Choosing Health: Making healthier choices easier

This paper (Department of Health 2005a) provides a detailed delivery plan of the key steps that need to be taken by the Department of Health in order to achieve the *Choosing Health* White Paper's objectives.

With regard to smoking and young people, it highlights the reduction in smoking exposure brought about through bans in all enclosed public places (unless licensed), restaurants, and pubs and bars serving food. It also stipulates an end to internet advertising and brand sharing in the UK from July 2005. A stronger regulatory framework is also to be developed, with new mandatory picture warnings on tobacco products. There will also be strong adherence to asking for ID with tobacco sales; with fines and bans for retailers found to be slacking in this area.

Primary Care Trusts

Primary Care Trusts (PCTs) are responsible for administering the priorities and targets set out in the Department of Health's *Priorities and Planning Framework* (2002) at the local level. Within this role, targets have been developed for a range of health-related behaviours, including smoking. One of these targets is the 'four-week smoking quitters' and refers to the number of smokers who quit by the time of their four-week follow-up with the NHS smoking cessation services. This indicator looks at actual performance against planned number of quitters.

PCTs are also involved in ensuring that appropriate advice on smoking is given to those with coronary heart disease, as well as reducing the proportion of women continuing to smoke by one percentage point a year. However, in the *Priorities and Planning Framework*, there are no targets set for reducing smoking prevalence specifically among young people. Nor are there targets set in relation to the provision of cessation services especially for them.

The role of the Health Development Agency¹ and NICE

The Health Development Agency (HDA) carried out a Smoking Research Programme for some years and published some interesting findings on: smoking and the impact of the mass media; tobacco use among minority ethnic groups; consumer views on different types of smoking cessation products and services; and how smoking might be tackled through partnerships (HDA 2000, 2001). There has not been a specific research piece by the HDA on young people, but there are sections embedded in existing reports that broach the issues of young people and smoking rates. In 2005 the HDA was merged with the National Institute for Health and Clinical Excellence (NICE) and past HDA publications are held on the NICE website. NICE continues to develop guidance on smoking.

National Healthy Schools Programme

The National Healthy Schools Programme, launched in 1999, is jointly led and funded by the Department of Health and the Department for Children, Schools and Families (DCSF). Through drawing strategic partnerships between local PCTs, local education authorities (LEAs) and other non-statutory agencies, it aims to operate a 'whole systems approach' to education and health improvement. It tries to involve the whole-school community, including parents, in establishing levels of need, agreeing targets, and assessing the impact of activities. In terms of tobacco smoking, its target is to reduce the rate of smoking in accordance with national targets, primarily through providing school-based cessation services.

¹ Now the National Institute for Health and Clinical Excellence (NICE)

Guidance on drugs for schools

The DfES (now DCSF) (2003b) issued guidance for schools that includes advice on how best to implement drug education for both legal (for example tobacco) and illegal drugs. This stresses the need to take diversity, special needs, family smoking patterns and gender into account in teaching sessions. The guidance also promotes teaching life skills such as effective communication, interpersonal skills, decision-making and coping skills. It further highlights the importance of interactive learning through discussion and role-play.

The limitation of this guidance, however, is that it is up to schools to decide whether or not to follow it. It is also for them to determine how drug education is organised, and whether it is carried out through timetabled PSHE (Personal, Social and Health Education), other curriculum subjects such as citizenship and science, extra-curricular activities, or a combination of approaches.

QCA Drug, Alcohol and Tobacco Education guidance

The Qualifications and Curriculum Authority (QCA) keeps the national curriculum for England under review and leads on its development. It addresses drugs education and tobacco education as part of a wider package of guidance, training and support, which includes the drug education package for teachers (QCA 2003). This provides starting points for teaching and learning activities to deliver drug education that encourages young people to reject drugs. The approach is to give accurate information about physiological and psychological effects of drugs, together with the implications of drug use on the individual, family and wider society. Teaching skills to resist pressure to experiment with drugs are also highlighted as an important strategy of drug education. The importance of young people making informed choices is also seen as central to drug education. In the secondary curriculum review for the 2007/08 academic year, Drugs, Tobacco and Alcohol education comes under personal well-being, which alongside economic well-being makes up the two non-statutory programmes of study for personal, social, health and economic education (PSHE Education). Bringing these two strands together in one subject area is designed to promote a more coherent curriculum, the programmes of study building on the existing frameworks and guidelines in these areas.

PSHE and Citizenship Curriculum Framework

This framework (DfES 2003a) leads on from QCA guidance in this area. It highlights how, throughout the key stages of learning, the level of understanding about tobacco, alcohol and drug use – including health risks (short- and long-term) and legality – must be built upon, and how students must be encouraged to make healthy choices. There is also an emphasis on teaching students to recognise peer pressure and to develop skills to resist

such pressure. The Education and Inspections Act 2006 places a duty on schools to promote well-being.

Healthy Living Blueprint for Schools

The Healthy Living Blueprint, launched by the DfES (now DCSF) (2004b), aims to support schools in helping children to lead a healthier lifestyle. One particular objective is 'to promote an understanding of the full range of issues and behaviours which impact upon lifelong health' through linking healthy lifestyles and emotional well-being. Strategies for tobacco education aimed at reducing smoking or delaying its onset, include support networks such as peer mentoring and services such as drop-in health clinics at extended schools.

The National Drugs Strategy

The *Updated Drug Strategy 2002* (Home Office 2002) focuses on the use of illicit drugs, and smoking does not fall within its remit. Nonetheless, it does acknowledge that use of illicit drugs does not occur in isolation and that it is often linked to tobacco smoking. The revised drug strategy due in 2008 will reassess patterns of drug use and refocus on the approaches and strategies that have had the most positive impact.

At the heart of the government's drug strategy is Blueprint, which is the first major research-based multi-component drug education project in the UK undertaken in partnership by the Home Office, the DCSF and the Department of Health. This project aims to provide evidence of what works in educating 11- to 13-year-olds about the risks of drug use and, in the longer term, research-based information on reducing the number of young people who become involved in using drugs of all kinds. For the purposes of Blueprint, drugs are defined as substances people take to change the way they feel, think or behave, and include medicines, volatile substances, alcohol, tobacco, caffeine and illegal drugs. The programme involves 29 secondary schools in four LEA areas and is due to run until 2007.

Drug Action Teams

Drug Action Teams, or DATs, are local multi-agency coordinating groups set up under the UK government's strategy for England, entitled *Tackling Drugs Together* (Home Office 1998). In conjunction with the directors of children's services they are expected to agree joint targets to address children and young people's substance misuse, based on an assessment of local needs. These targets form part of the wider Children and Young People's Plan which each local authority produces as part of their duties under the Children Act 2004. This joint approach, and the actions required at local level, are described in *Every Child Matters: Change for Children – Young People and Drugs* (HM Government 2005). Although DATs cover smoking, the main focus for targeted interventions are alcohol, drugs and volatile substance abuse. Many DATs are merged or synonymous with their local Community Safety

Partnerships (CSPs). Neither DATs nor CSPs are statutory bodies but both have statutory responsibilities.

Reducing the impact of secondhand smoke on children

The 1997 Declaration of the Environment Leaders of the Eight (G8 1997) on Children's Environmental Health included the following statement.

We affirm that environmental tobacco smoke is a significant public health risk to young children and that parents need to know about the risks of smoking in the home around their young children. We agree to cooperate on education and public awareness efforts aimed at reducing children's exposure to environmental tobacco smoke.

This has recently been followed up by the first ever international legally binding public health treaty, the Framework Convention on Tobacco Control (FCTC), which came into force in 2005 and has now been ratified by some 148 countries including the UK (www.who.int/tobacco/framework/en/). The FCTC makes clear:

Parties recognize that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability.

and, as a result, that parties should adopt and implement measures:

providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

This commitment to limit tobacco-smoke environments for children at the international level has recently been matched by national policy and action in this area. The smoke-free legislation, smoking in enclosed or semi enclosed public spaces in England came into force on 1 July 2007 and should further reduce the exposure of young people to secondhand tobacco smoke.

Before the enforcement of the smoke-free legislation ban there had been some effort to encourage pubs and restaurants to have 'no smoking areas' through a voluntary Public Places Charter (Department of Health 1999b) and an attempt to develop an Approved Code of Practice about smoking in the workplace (Health and Safety Commission 1998). As these failed to deliver real change legislation was embarked on following the publication of the Choosing Health White Paper in November 2004.

Smoke-free schools (where the whole school is designated a smoke-free area) were also common before the legislation and are thought to discourage smoking by creating a negative social norm around tobacco use, as well as limiting smoking role models. The smoke-free school initiative has been

reinforced through the National Healthy Schools programme that uses it as one of the criteria for a Healthy School. As part of the updated Healthy Schools Standard schools are required to have implemented a non-smoking policy – which applies to all smoking within schools grounds – or be working towards being completely smoke-free by September 2007.

The new legislation and national initiatives will, so far as children and young people are concerned, be important in reducing general levels of tobacco exposure.

2. Risk factors for smoking

In order to better understand the successes and failures of previous interventions to reduce levels of smoking in young people, and to identify the target groups for future interventions, it is important to understand why young people start smoking and the personal characteristics that seem to make this more likely. What is it that makes young people susceptible to smoking and resistant to giving it up? Greater knowledge in these areas facilitates effective strategies aimed at appropriate target audiences (Abel and others 2002; Filice and others 2003; Denscombe 2001a).

A wide range of factors has been examined and implicated in young people's smoking behaviour. The following list, while not exhaustive, includes those that seem particularly important. Some represent personal and demographic characteristics, while others are more related to social and cultural factors. Many provide pointers to inform future prevention and cessation programmes.

Age

It has been indicated that the risk of starting to smoke increases between 12 and 16 years (DeWit and others 1997) and falls significantly after the age of 20 (Thomas and others 1998). Nonetheless, it appears that while age might make young people more or less susceptible, other processes and experiences can interact with age in determining risk at any point in time. In a US study, for instance, Filice and others (2003) found short periods of increased or decreased susceptibility during adolescence, even for those thought to be particularly vulnerable to smoking initiation. Young people in the ninth grade (aged 12–13), which is the first year of high school, were particularly susceptible to taking up smoking, but this susceptibility was reduced by the end of the tenth grade. It seemed, according to the authors, that the period of heightened risk was attributable to a change of school and the idea that smoking led to higher social status in the young people's new educational environment. Similar findings emerged from a UK study carried out by Lloyd and Lucas (1998). This found that the transition from primary to secondary school, which usually means a move from larger, more flexible peer groups to those that are smaller and where peer influence is more important, encourages identity formation, especially for young women. At this time, the positive 'looking tough' and 'being cool' stereotypes associated with being a smoker can make smoking an attractive proposition.

Pointer

The suggestion that young people may be particularly prone to start smoking as they transfer to secondary school is interesting and worthy of further exploration. If found to be the case, this would indicate that the very initial stages of secondary school provide important opportunities for prevention. More information on the perceptions of smoking held by primary school children could also be helpful for interventions at this younger age to minimise

the risk of later smoking behaviour at the point of transition to secondary school.

Sex differences

The most striking inequality in smoking rates is between teenage girls and boys. In a recent survey of drug use, smoking and drinking among young people in England in 2003 (Department of Health 2003), it was found that smoking was reported by 16 per cent of 14-year-old and 26 per cent of 15-year-old girls, but only 9 per cent of 14-year-old and 18 per cent of 15-year-old boys. This gender difference is important and raises the question of whether girls and boys are exposed to different risk factors or whether they show different patterns of susceptibility.

Amaro and others (2001) highlight the growing evidence that certain risk factors might be more important for girls, and point to the possible role of negative self-image or self-esteem; weight concerns and dieting; eating disorders; physical and sexual abuse; higher levels of anxiety; depression; peer pressure; and drug use by a boyfriend. Other studies provide some support for this position – for instance, in consistently finding that girls between 14 and 18 years are at greater risk of depression than their male peers (Kandel and Davies 1982). Wilson and others (1994) also report that the early onset of puberty among girls is associated with greater vulnerability to multiple risk factors, such as smoking, drinking and early sexual intercourse. Similarly, certain protective factors, including parental support and consistent discipline or self-control, might be more important for girls.

Another possible interpretation of the gender gap is that boys and girls smoke for different reasons. Sarigiani and others (1999) found that boys frequently said they smoked to cope with social insecurity, whereas girls were more likely to say that smoking helped them to feel more confident, rebellious, socially advanced, or sexually experienced. Girls who smoked were also more likely than either boys or non-smoking girls to say that smoking is linked with social approval. Lloyd and Lucas (1998) reported that adolescent girls were more likely to say they smoked to 'look hard' than to stay skinny.

Pointer

There are marked differences between the sexes in smoking behaviour: girls smoke far more than boys and the factors putting them at risk are different. These observations suggest that different prevention and cessation strategies should be targeted at girls and boys.

Family factors

The family is described as the 'primary social agent in the promotion of health and well-being' (WHO 1976). Research has shown that health risk factors cluster in families where members tend to have a common physical environment as well as similar diets, activity patterns, and behaviours such as smoking and alcohol use (Campbell and Patterson 1995; Carnegie Council on

Adolescent Development 1995; National Institute of Nursing Research 1993). Furthermore, young people whose parents smoke are twice as likely to smoke than children of non-smoking parents (ONS 1998; Department of Health 1998b, 2003) and that the highest rates of smoking occur in households where an older brother or sister smokes (Pierce and others 1998; Royal College of Physicians 1992).

Parenting style, more generally, may also be important. A study by the Joseph Rowntree Foundation (1996) found that parental style was the main influence on whether young people became involved in certain behaviours such as smoking. Children of parents who are overbearing, inconsistent, or lax are at by far the greatest risk of becoming regular smokers. A US study has reported that teenagers are at high risk of smoking, drinking or using illegal drugs if they have a poor relationship with their father (Califano 2000).

These findings have been confirmed by a study of the health lifestyles of 15-year-old smokers in Scotland (Todd and others 1999). This found highly significant associations between parental smoking and adolescent smoking; adolescent smoking (for both boys and girls) and the number of smoking parents; smoking status and whether or not adolescents saw their parents as approving or disapproving (that is, smokers were more likely than non-smokers to believe their parents would not mind if they smoked in two years' time); and smoking and whether or not the adolescent cared what his or her parents thought.

Pointer

The influence of family smoking rates, family discipline and general family relationships on young people's susceptibility to smoke suggests that a 'whole family approach' to intervention may sometimes be most appropriate. There is growing evidence that parenting education has a beneficial effect on drug and alcohol use by young people (Guyll and others 2004; Spoth and others 2001).

Ethnicity and culture

In general, cigarette smoking among minority ethnics is less common than within the UK population as a whole (HDA 2000). Nonetheless, smoking rates vary considerably among ethnic minorities and also between men and women within these groups (ASH 2002b). The Health Survey for England (Department of Health 1999a) illustrated, for instance, how the rate of smoking is 42 per cent (compared to the national average of 27 per cent) for Bangladeshi men, while for Bangladeshi women it is only 2 per cent (compared with 27 per cent for women). Although it might be expected that similar differences would be found for young people from different ethnic groups, there is a lack of information to answer this question one way or the other.

The variable susceptibility of minority groups to illness points to the possible differential risk of smoking between cultures. There is, for instance, an increased risk of heart disease among South Asian groups (HDA 2000) that could be relevant.

Some cultural groups, and particularly South Asian groups, use smokeless tobacco in products that may particularly appeal to children. These include *bidis*, which are small, thin unfiltered cigarettes that are considerably cheaper than western, manufactured cigarettes and are often flavoured with chocolate, strawberry or cardamom. Such products are marketed to appeal to young people, and have been shown to encourage under-age smoking (Champion and others 2001).

Pointer

There is a general lack of information on similarities and differences in smoking behaviour across ethnic groups, especially for young people. This issue needs to be addressed if interventions for these groups are to be appropriate and effective.

Social status

Although social status does not appear to affect young people's smoking patterns as much as it does adults', it can still make an impact. Jarvis (1997) found that children from less advantaged social backgrounds are more likely to start smoking than children from more affluent backgrounds, but the difference is not great. However, by their thirties, half the better-off young people have stopped smoking while three-quarters of those in the lowest income group carry on. Woods and others (2005) also found that children of primary school age were more likely to have tried smoking if from a low socio-economic group. Such findings are important when considering the focus of intervention, and have been supported by studies suggesting that nicotine dependence increases systematically with deprivation. Furthermore, it seems that poorer smokers achieve higher intakes of nicotine both by smoking more cigarettes and by smoking each cigarette more intensely, and thereby face enhanced health risks and greater difficulty in quitting (ASH 2005). These findings, however, relate to adults and it is not clear whether or not similar patterns are found for young people.

Pointer

There needs to be more investigation of smoking patterns among young people from different social backgrounds. There is a suggestion that, although social groups are equally in need of prevention programmes, more disadvantaged groups may especially benefit from cessation programmes.

Invulnerable youth

It has been suggested that young people do not necessarily regard themselves as vulnerable and may take the view that they are not susceptible to the health risks normally associated with tobacco. While surveys consistently find that nearly all regular smokers believe that smoking causes lung cancer and heart disease, between 20 and 40 per cent of young regular smokers endorse the view that 'smoking is not really dangerous, it only harms

people who smoke a lot' (Foulds 1999). In Brigham's (1998) view, youth has an optimism of its own.

It is a feature of many adolescents to believe that they can run and not be weary, drive fast and not crash, stay up all night and be normal the next day, and do dangerous things without consequences. If there are consequences, adolescents typically believe that the consequences are so distant that they don't matter now.

There is, in addition, some evidence that young people may even see tobacco as, in a sense, health promoting. A survey carried out by MORI (1999) indicated that many young people point to distinct advantages of smoking. Teenagers said that the main reasons they took up smoking were that it put them in a better mood, made them more confident and helped them to make friends. The NHS website points to the myths of smoking for young people being: 'smoking helps me chill', 'smoking is sexy', 'smoking makes me look mature' and 'smoking keeps me skinny'.

In short, a cost-benefit analysis of smoking for young people can stress the positive perceived social and personal benefits to be gained from smoking at the expense of the negative health effects. Ultimately, for some young people who take up smoking, it seems that these short-term 'benefits' can outweigh the long-term physical dangers.

Pointer

It is clear that interventions to reduce smoking need to take account of young people's attitudes and perspectives, and should be appropriately targeted throughout the lifespan.

Addiction and the difficulty of quitting

A survey of attitudes to smoking (Schools Health Education Unit 2003) found that some three-quarters of young people who smoke want to give up, a rate not dissimilar to that among adults. Furthermore, many teenagers express the desire to quit and may try to give up within a very short time of starting (McNeill 1991; Grimshaw and others 2003). Nonetheless, it is clear from past research and anecdotal experience that the process of giving up smoking is very difficult and takes several attempts to achieve (Burt and Peterson 1998; Stanton and others 1996). Young people tend to be overconfident about their ability to give up, with the majority of occasional smokers (82 per cent) perceiving themselves as 'very likely' to succeed (Grimshaw and others 2003). In short, young people do not seem to realise the addictive nature of smoking and often postpone giving up by setting themselves goals for doing so 'when I leave school', or 'when I go to university' (Royal College of Physicians 1992). They are also unlikely to quit on their own without help (Denscombe 2001a).²

² While this could also be the case for older smokers, these studies looked only at adolescents. Without a comparison study it is difficult to conclude whether lack of support in giving up is more of a problem at a younger age.

Pointer

The fact that many young people want to quit smoking reinforces the need for cessation services for them. The additional fact that smoking can be very difficult to give up, however, means that these services may need to expect only moderate levels of success unless the interventions are sustainable.

Peer pressure and self-identity

For some young people, peer pressure and self-identity may be instrumental in encouraging them to smoke. Social identity and status within the social network play a key role in health-related behaviour such as smoking (WHO Europe 1998). This was suggested by Lloyd and Lucas (1998) who found that teenage girls may start smoking to appear tough and attract older boyfriends, and also indicated by Denscombe (2001a, 2001b) who reports how 'uncertain identities' seemed to contribute to high rates of smoking among 15- and 16-year-olds in the East Midlands of England. It seemed that smoking helped many young people to cope with a lack of social confidence.

Pointer

If smoking can enhance self-esteem and social confidence, one approach may be to develop other ways to encourage these feelings of well-being among young people. A range of alternative strategies to promote mental health and well-being would be likely to meet with the most success.

Exposure to tobacco and tobacco smoke

A study by Ferrence and Ashley (2000) has shown that the noxious effect of the first cigarette may play a key role in determining whether children take up smoking. This is important given that children who breathe other people's smoke become desensitised and less likely to suffer the strong reaction that may deter them from taking up the habit. Passive smoking is thus not only a problem for a child's health in general but can also act as a risk factor for ensuing tobacco addiction.

WHO estimates that half of the world's children breathe air polluted by tobacco smoke. This exposure is involuntary and happens in areas of play, sleep and living (WHO 1999). The fact that this exposure is involuntary is a very serious issue in terms of the human rights of the child. Article 3 of the UN Convention on the Rights of the Child states that in every decision affecting a child, the best interests of the child shall be a primary consideration.

Pointer

For a wide range of reasons, an important element of any anti-smoking strategy is quite simply to reduce opportunities to smoke. Bans, restrictions and other measures are important in this context.

Educational achievement

There is some evidence that smoking is linked with educational achievement among young people, even if the direction of association is not clear. A study of the lifestyles of 15-year-old smokers in Scotland (Griesbach and Currie 2001) found that adolescents who reported doing well at school were significantly less likely than others to smoke. Furthermore, smokers were much more likely than non-smokers to have low aspirations for their future education, more likely to have negative feelings about their school, and more likely to have skipped classes for four days or more in a single term.

Hu and others (1998) found, from a Californian study, that students' school performance was a key factor in predicting smoking and quitting attempts once other socio-economic and family income factors were controlled. They concluded that developing academic or special needs classes designed to improve students' academic performance may not only lead to a reduction in smoking rates among teenagers but also simultaneously provide human capital investment for their futures.

Pointer

These findings reinforce the link between smoking and relative disadvantage and highlight the important role of educational achievement. The school setting is likely to be influential and the impact of initiatives such as Healthy Schools may well be key. It is again likely that specific groups of young people may require specific strategies.

Smoking and mental health

There is also an established link between smoking and mental health. Although there is a less than clear understanding of the nature of the association, the more likely direction of effect is that mental health factors predispose someone to smoking rather than the other way around.

Table 2.1 shows the proportion of children aged 11 to 15 years identified by an Office for National Statistics survey of children's mental health, showing specified disorders according to whether they are regular smokers or have never smoked.

Table 2.1: Mental disorders and smoking among children aged 11–15 years (percentages)

	Emotional disorders	Conduct disorders	Hyperkinetic disorders	Less common disorders	Any mental disorder
Regular smoker	20	28	4	2	41
Never smoked	4	3	1	0	7

Source: Meltzer and others (2000)

Pointer

The raised incidence of smoking among certain groups of young people is again highlighted. Smoking is often a factor associated with health and social 'risks' in other areas.

Links with diet

Smoking among young people often appears to be linked with unhealthy eating habits and the belief that smoking will help with weight reduction (Camp and others 1993). This is backed up by research in the USA (Lowry and others 2002) that suggests that teenage girls are taking up smoking to keep their weight down. A strong correlation was found between those who placed a high value on being thin and those who had smoked more than 100 cigarettes a week.

Associations between smoking and diet are complicated by the fact that these are two aspects of 'unhealthy' lifestyles that show strong links with socio-economic status and relative deprivation. This may be the interpretation of evidence from the study of Scottish health lifestyles of 15-year-old smokers (Grisbach and Currie 2001) which found a clear association between smoking, a poor diet, a lack of exercise (for boys only), getting drunk, using cannabis and reports of frequent (at least once a week) minor health complaints.

Pointer

Smoking is linked with both unhealthy eating habits and a wish to lose weight. The implication may be that anti-smoking strategies should include an emphasis on healthy diets as well as how to maintain a healthy weight and body image.

Links with other drug use

Although links have often been reported between smoking and more serious substance abuse, the nature of the association is less clear. Such links may be due to one form of experimentation leading to another, or they may be because young people with certain characteristics are particularly likely to experiment with a range of substances. Furthermore, while the nature of the link may be exacerbated by psychological factors, it might also be due primarily to social factors such as relative deprivation, poor achievement at school, and living with families who smoke, misuse alcohol or take illegal drugs.

Whatever the interpretation, there is some demonstration of links between smoking and the use of other drugs. A MORI survey on teenage smoking (MORI 1990) found that regular smokers were more likely than non-smokers to be regular drinkers (49 and 6 per cent respectively said they drink regularly). In addition, half the regular smokers – but only 2 per cent of the non-smokers – reported that they had tried illegal drugs.

Pointer

Such evidence not only suggests that smoking may encourage other drug use, but also that certain personalities may be more prone to smoke as well as to try other, more dangerous, drugs. The limited evidence on associations makes it difficult to interpret evidence on this question with any certainty.

Vulnerable groups

While it has been argued that young people in general are vulnerable to smoking initiation, there are particular groups of youths, in addition to those that are from low-income families (see Jarvis 1997) that are more likely to take up smoking. DrugScope (2001) found that smoking prevalence (as well as general drug misuse) is particularly high among rough sleepers, looked after children, youth offenders, young people excluded from school and children of drug-using parents.

An ONS report (Meltzer and others 2003) found that 32 per cent of the young people aged 11–17 (27 per cent of 11- to 15-year-olds and 44 per cent of 16- to 17-year-olds) looked after by local authorities were current smokers; and only 36 per cent had never tried smoking (41 per cent of 11- to 15-year-olds and 22 per cent of 16- to 17-year-olds). Of the children in residential care, 69 per cent were current smokers, reflecting the greater proportion of older children in these placements. These numbers are significantly higher than those for young people in general, and are a cause for concern. This group is perhaps more vulnerable to the types of risk factors listed above, but more research is needed.

A *Findings* report from the Home Office (2003), focusing on the young homeless, found that nearly all the young people (aged 16–25) surveyed for the study smoked, and had 15 cigarettes a day on average. Overall, the young homeless reported much higher levels, both of smoking generally and

of smoking hand-rolled cigarettes in particular, than young people in general. Whilst these findings did not include a breakdown of the ages, there is a strong indication that young homeless people are particularly in need of smoking cessation assistance.

Pointer

While there is evidence to suggest that certain groups of children and young people are particularly vulnerable to smoking, there is a lack of in-depth studies to understand the reasons why.

3. Prevention and cessation

A considerable amount of energy has been directed towards the reduction of smoking among young people, but unfortunately no strong and clear messages for intervention have yet emerged. Evidence on those most at risk, and the factors making young people susceptible to tobacco use – as outlined above – have assisted in targeting the appropriate groups, and a wide range of approaches and initiatives have been implemented. However, evaluations of interventions focused on prevention have been difficult as numbers are usually small and the long-term effects of such programmes are rarely monitored (Sowden and Arblaster 1998). There is also a disparity between the number and quality of evaluations on prevention and cessation services. As Aveyard and others (1999) conclude, on the basis of their review of the literature, 'current initiatives to encourage cessation are directed at adults' and relatively little attention has been given to smoking cessation among young people.

The following sections illustrate the range of approaches that have been taken to reduce smoking among young people. Although some focus specifically on either prevention or cessation, many employ more general strategies to have a potential impact on either. Approaches may be designed to be undertaken in school or elsewhere, and they may be led by adults, peers, family or the community. Young people may be directly or indirectly targeted, or participation may be elective. Some strategies directly involve young people as individuals or groups, while others may be more about restricting access to cigarettes or reducing opportunities for smoking. Sometimes strategies are about trying to heighten awareness of the dangers of smoking, or reducing exposure to positive messages through advertising. In some cases there is evidence of effectiveness, but in others there is none.

The school curriculum and school programmes

Many smoking prevention and cessation interventions are undertaken within the school setting. Initiatives may focus on providing information in a fairly factual manner through the school curriculum, or they may try to 'personalise' information in order to encourage young people to challenge their own behaviour more directly. They are very often focused on life skills rather than straightforward information giving or awareness raising.

School-based approaches to smoking prevention include input into the school curriculum and, indeed, education is one of the key components of the government's drug strategy. The drug, alcohol and tobacco education curriculum guidance for schools at Key Stages 1–4 (Qualifications and Curriculum Authority 2003) stipulates the following:

Drug, alcohol and tobacco education is an explicit, planned component of personal, social and health education (PSHE) ... Drug, alcohol and tobacco education provides a context for enabling pupils to increase

their knowledge and understanding of drugs, alcohol and tobacco, and to explore attitudes and develop skills for making healthy, informed choices. It should be supported by school values and an ethos that have been developed by all members of the school community; positive relationships within the school and between the wider community; the whole-school policy and practice that is consistent with the aims of the drug, alcohol and tobacco programme.

PSHE classes are meant to build on the statutory science curriculum, stressing attitudes to drugs and alcohol and their perceived social components. The National Curriculum guidelines for science state that:

- at Key Stage 1, 5- to 7-year-olds should learn about the role of drugs as medicines
- at Key Stage 2, 7- to 11-year-olds should learn that tobacco, alcohol and other drugs can have harmful effects
- at Key Stage 4, 14- to 16-year-olds should learn about the effects of solvents, tobacco, alcohol and other drugs on body functions.

Furthermore, PSHE lessons should look at the laws surrounding such issues, school policy and smoking within the wider community. Advice on teaching and learning approaches for PSHE tobacco education includes the use of participatory approaches such as group work, simulations, drama, discussion, debate, structured games and action research as well as more formal styles of teaching. Based on Tobler's (2001) work, it is advised that PSHE programmes have in-built elements of interpersonal skills, such as assertiveness, intra-personal skills (for example, self-esteem and coping skills), as well as the more traditional knowledge component of education. QCA guidance also offers some advice on these aspects, although generally covers what drugs students should know about at different Key Stages.

Some interesting education programmes with a focus on critical and personal thinking about smoking have been developed in the USA. A good example is the Tobacco Education Group (TEG), designed for adolescents not yet thinking about quitting, for which the curriculum includes examination of personal reasons for smoking or chewing tobacco; pressures to use tobacco; and demonstrations of short-term, and discussions of long-term, consequences of tobacco use. The main aim of this programme is to motivate smokers to want to stop, and students caught smoking are assigned to the TEG programme as an alternative to suspension. A parallel tobacco-cessation programme, this time designed for adolescents who want to stop smoking, is the Tobacco Awareness Program (TAP). This has a focus on short- and long-term consequences of smoking; triggers to tobacco use and coping strategies; pitfalls to be expected during and after quitting; use of culturally sensitive materials; weight management; and individual choice of methods to quit.

An evaluation of these programmes (Coleman-Wallace and others 1999) demonstrated that cigarette consumption decreased in both programmes, but that a greater change occurred among the participants of TAP than those of TEG. Also, the TEG and TAP interventions appeared to increase adolescent self-efficacy to resist smoking.

Since the programmes were conducted in groups, the evaluators felt that group pressure played a role in their success. Interestingly, it was also found that all participants worried similarly about getting cancer from tobacco use and regarded smoking as a problem – which suggests that they did not see themselves as immortal. These results confirm that neither knowledge nor fear are adequate motivations for adolescents to want to quit tobacco use. The success of these programmes was also attributed to their specific focus on strategies to stop smoking.

The role of school nurses

School nurses work between health and education and are in a prime position to help prevent and reduce smoking among young people. They also have a strong tradition of working with individuals, families and school communities to promote health. New guidance strengthens their roles in providing smoking education and cessation services.

The Health Visitor and School Nurse Development Programme offers a practice development resource pack (Department of Health 2001) with guidelines on how school nurses should be involved in helping young people to stop smoking. The guidance suggests that school nurses can:

- consult young people in offering smoking cessation groups and encouraging peer group strategies
- monitor any new local tobacco-marketing strategies
- press for no-smoking policies in schools and challenge smoking in front of pupils
- enlist the help of young people to support National No Smoking Day with displays and activities
- work alongside the primary healthcare team to ask individuals if they want to give up, highlight the health benefits from giving up, make young people aware of the services available to help them, help young people plan their withdrawal, and offer to follow up with support.

Joint working within the Healthy Schools Programme further stipulates that school nurses play a key role in supporting schools in the development and delivery of PSHE, and in building pupils' confidence to access advice from primary care. School nurses are in contact with children living in local communities and have a role to play in helping them make healthy lifestyle choices and reduce risk-taking behaviour. Bridging health and education services, they are able to provide a contribution to Citizenship as well as to PSHE.

Although school nurses are in a unique position to assist in smoking cessation programmes within schools, they are in short supply. There has also been very little evaluation of their current role in this area and little examination of their effectiveness. With the recently announced drive to employ more school nurses (see *Choosing Health*, Department of Health 2004b) this could present an opportunity to push the school nurse role in smoking advice and cessation to a more effective level.

Improving emotional well-being

A number of studies have suggested that young people who smoke may have lower self-esteem than their peers. Some interventions have therefore attempted to improve emotional well-being in the hope that a spin-off would be a reduction in smoking and smoking-related behaviours.

The Gatehouse Project in Australia, which began in 1997, is an example of such an approach. This project employed a randomised controlled trial to determine whether the implementation of school-based intervention, that included both individual and environment-focused components, could improve students' emotional well-being and have a positive impact on behaviour. The programme was targeted at 13- to 14-year-olds in a secondary school setting. It provided schools with strong conceptual and operational frameworks to enhance understanding of adolescent mental health needs as well as an evidence-based process for planning, implementing and evaluating a practical intervention. The programme aimed at enhancing emotional well-being in terms of a feeling of security and trust, communication and social connectedness, and a sense of positive regard though valued participation in aspects of school life; and participants were encouraged to develop and practise strategies to deal with difficult emotional situations.

Bond (2004) reports that this project was effective in reducing adolescents' health-risk behaviours, particularly in relation to smoking. However, it failed to have an effect on depression and depression-related problems.

Social skills training

It has been suggested that social skills training is a key component of successful intervention programmes to reduce smoking among young people (Vandyke and Riesenbergh 2002). Some programmes using 'life skills' training components have, for example, witnessed a 30 to 50 per cent reduction in drug use over a one-year period (Epstein and others 2000; Botvin and Botvin 1992; Botvin and Wills 1985). The message conveyed by such studies is that life skills training should be presented early to young people and followed up with reinforcing booster sessions. These projects are also known as normative education because they focus on realistic knowledge of tobacco and other drug use among peers. There is considerable support for this approach as an important mediator of successful prevention programmes (Bandura 1997; Donaldson and others 1994).

Two social skills programmes in the UK have reported positive results in reducing substance use. One of these, Project Charlie, is a multi-component life skills programme for primary school children incorporating training in resistance skills; peer selection; decision-making and problem-solving; self-esteem enhancement; and the provision of factual information. Although this programme was not specifically directed at smoking, it provides useful lessons and could well be adapted for this specific purpose. The evaluation of Project Charlie (Hurry and Lloyd 1997) indicated that the programme led to

greater knowledge about drugs, a greater ability to resist peer pressure, and the ability to produce more and better solutions to social dilemmas.

Another multi-component life skills programme, the Hampton Intervention and Prevention Program (HIPP), takes this strategy one step further. HIPP is a multi-component multi-channel programme that provides a continuum of prevention and intervention support from nursery school through to high school (Carlson 1990). The curriculum includes factual information on alcohol and drugs; skills training for resisting peer pressure; decision-making advice; and activities that promote a positive sense of competence and self-worth. An evaluation of HIPP backed up the earlier findings of a review of the Illwarra Drug Education Programme in suggesting that life skills approaches targeted at primary school-age children can have an impact on future smoking, alcohol consumption and illegal drug use (Wragg 1990, 1992). The New Hampshire study in the USA (Stevenson and others 1996) reached similar conclusions.

Faggiano and others (2005) looked at 29 randomised controlled trials in a systematic review of drug prevention programmes in schools. They found that programmes that teach students how to resist peer pressure, to become more assertive and to make better decisions are the most successful. Knowledge-based programmes, along with those that focused on the psychological causes of drug use were found to increase knowledge of drugs, but did not change their likelihood of trying them.

Delivery methods in teaching drug refusal skills were also found to be key in terms of its success (Ennett and others 2003). The use of participatory teaching methods in lessons was found to be important, for example, encouraging active exchange between students and between the students and instructors.

Peer-led initiatives

The recognition that peer pressure can influence young people's smoking behaviour has led to the introduction of peer-led initiatives to reduce levels of tobacco intake. Erhard (1999) reviewed some of the programmes available at that time and contrasted them with adult-led prevention programmes. There were three types of content within the programmes he looked at and these were cognitive (information on drugs, the damage they caused and legal problems); personal-effective (promoting resistance to social pressure, developing assertiveness and assisting in coping with stressful situations); and attitudinal-social (who is a good friend, advertising and so on). Strategies included class discussions, invited speakers, going to see a play or film, meeting ex-addicts and inviting parents to lectures.

The peer-led programmes were generally favoured and achieved more than adult-led programmes on all input (content, atmosphere, openness, discipline, facilitators' competence) and outcome (satisfaction, knowledge, avoidance, curiosity, personal relationship) measures. While there were no clear statistics on a reduction of smoking as such, students explicitly stated that they preferred their classmates to adults as facilitators of a prevention programme.

They liked the programme with classmates and wanted more lessons of this kind.

Another peer-led model, using a 'diffusion of innovation' approach, was evaluated by Bloor and others (1999) and shown to have some limited impact on smoking itself. The programme sought to influence behaviour by recruiting 'popular' students to the anti-smoking campaign. These 'peer leaders' were then professionally trained and supported to intervene successfully in everyday situations with their peers to promote smoking prevention and cessation, and to monitor the outcomes of their interventions. Although expensive in terms of time, staff and resources, the intervention did have some success in stopping pupils taking up smoking, or taking it up again. For those who had been smoking for three months or more there was, however, no success with cessation. The paper points out that it was difficult to motivate peer-leaders, and especially difficult to recruit boys.

Family-centred programmes

As discussed earlier, the family plays a central role in a young person's health behaviour. Feetham (2000) uses this premise to argue for family-based programmes. In her opinion health programmes involving health promotion for urban children require four characteristics if they are to have positive long-term effects. First, programmes must be comprehensive and focus on more than one health-risk behaviour. Second, they must start in early childhood and continue through life (Washington 1999). Third, the interventions must be framed in the broader context of the community, which includes social, economic and political environments (Ehiri and Prowse 1999). Finally, Feetham emphasises that health programmes should be conducted in the context of the family. Mortimer (1993) suggests that involving parents at all levels in school-based programmes could result in more effective partnerships to reduce risk behaviours. In summarising 100 successful programmes, Dryfoos (1990) was more direct and suggested targeting outreach to parents through home visits, and providing them with specifically defined roles such as classroom aides and advisory board members. Such programmes could also help to reduce adult smoking in children's environments.

An interesting example of a generic parenting programme is the American Strengthening Families Program (SFP). This is a selective prevention intervention that, in contrast to universal prevention interventions, targets high-risk individuals or families. SFP was first developed for elementary school children (aged 6–12 years), but has proved effective for other high-risk, conduct-disordered children as well as culturally diverse youth (Kumpfer and Alvarado 1995). The SFP is an intensive 16-week family skills training programme involving the whole family. Participants do not necessarily have behavioural or emotional problems but are at risk of later substance abuse, delinquency and school problems. A five-year follow-up study suggests the programme is successful in reducing substance abuse and delinquency and in improving educational achievement. Parents reported that they had gained significantly from the exercise, and that family relationships had shown some improvement.

Community interventions

Recognition that young people's decisions to smoke are made within a broad social context has led to the development and implementation of community-based programmes (Sowden and Stead 2003). Community interventions often include multiple coordinated activities to support non-smoking behaviour, such as age restrictions for tobacco purchase, smoke-free public places, media campaigns and special programmes in schools.

One such community programme was initiated on the Channel Island of Guernsey in 1996. The legal age to buy cigarettes was raised from 16 to 18 years, tobacco advertising was banned, tax on cigarettes was raised by 8 per cent, smokers were offered a month's supply of nicotine replacement aids free, and each child between the ages of 8 and 18 was allocated at least three sessions a year with an anti-smoking youth worker. The programme appeared successful. Whereas 13 per cent of 12- to 13-year-old girls on the island had smoked in 1992, by 1998 this rate was reduced to only 5 per cent. The number of boys who smoke also fell.

More generally, however, Sowden and Stead (2003) found the results from community interventions to be mixed, and indicated that they worked best when combined with a school programme. Two studies that were especially successful in influencing smoking rates both targeted multiple sites within the community, such as schools, work sites and churches. Various media channels were also used to reinforce the message. This review points out that there is a real need to take local factors into account in community programmes to ensure these accurately reflect and target the population.

Specialist services

The 1998 White Paper *Smoking Kills* promised more effective cessation services, and targeted these in Health Action Zones to reach relatively deprived areas where populations are particularly likely to smoke. Despite problems such as staffing shortages and unrealistic time scales for developing these services (Adams and others 2000), smoking cessation services for adults have been developed and have demonstrated considerable success (Raw and others 1998). Strategies include brief interventions, intensive support either individually or in groups, and pharmacotherapy. These services have, however, had a prime focus on adults and it would appear that, at present, generic smoking cessation services are not, in general, successful in reaching young people (Stanton and Grimshaw 2002; Foulds 1999).

Grimshaw and others (2003) reviewed cessation services and found that only two out of 20 teenage interviewees had accessed a specialised young people's counselling service – one was Quitline and the other was a school health provision. Young people's knowledge of cessation services was very patchy. Some helplines were well known, and several knew about nicotine replacement therapy, but few had a real awareness of specialist clinics or groups. Young people did not want to be pressured into using services, and they did not want to be seen to be using them by their peers. They also

stressed the importance of autonomous quitting and said they were reluctant to share their experiences with strangers. The authors conclude that young people of this age are unlikely to be willing users of smoking cessation services provided in traditional settings or in conventional ways. Studies from Canada and the USA support this view (Balch 1998; Lawrence 2001).

In a separate evaluation of ten cessation services, Stanton and Grimshaw (2002) found that success was greatest where youth workers had credibility among young people, and that using a combination of these workers and school nurses to provide 'medical' knowledge could work well. The authors suggest that young people want both a youthful perspective in youth workers *and* recourse to experience and knowledge. Other aspects of services that seemed to help were reminders to attend meetings and text messaging which was seen as a 'cool' medium. However, these specialist cessation services still showed room for improvement.

Andrews (2004) reports on an evaluation of a specialist cessation service 'CHUCKIT' run for young people in Hull and East Yorkshire. Components of this programme include a free phone service as well as an email service for those not confident enough to call. The duration of support is determined by the needs of the young smoker; reminders and supportive text messages are sent to clients; problem-solving activities such as role-play are used to overcome peer pressure; and a logo and service identity are designed to attract the attention of young people. The service provides one-to-one support with specially trained youth workers, school nurses and learning mentors. These specialists are also given a mentor to aid them in their supportive work with young people. Recruitment to the service is through both advertising and education activities in schools. While Andrews points out the considerable signs of success of this programme, he emphasises that more long-term monitoring is needed. He also notes the difficulty that cessation services such as these have in meeting national targets, especially when outcomes and long-term effects are often not clear.

Nicotine replacement therapy

Whilst nicotine replacement therapy is a key part of the UK national strategy to stop adults smoking, it has so far not been much used with young people. A lack of clinical trials with those under 16 make it difficult to know what the likely impact and side effects might be (McNeill and Hendrie [for WHO] 2001).

Some services of this kind for children are, however, being tried. A pilot project in Nottingham, funded by the Cancer Research Campaign and the Imperial Cancer Research Fund, is planning to give nicotine patches to children as young as 12 in a drive to help them kick the habit. Counsellors are working with children at the Zone, a youth project on the Broxtowe estate in a disadvantaged area of Nottingham. The study is being led by John Britton, professor of respiratory medicine at Nottingham University.

As another example, a project at Blake School in Bridgewater has included nicotine patches in their programme to help pupils give up smoking. Young

people were encouraged to sign up for the scheme and used 'smokalisers' to measure the levels of carbon monoxide in their blood. The students were given incentive vouchers to stay in the scheme and their parents signed consent forms to allow them to be given nicotine replacement patches – a controversial decision, but one that Chris Burtin, an Avon health worker, says will double their chances of succeeding.

In Christleton High School in Chester (reported in *The Times*, January 2002), the headteacher has been allowing pupils to smoke in an allocated area within the school grounds as part of an experiment to help them give up the habit. At the time of print, 28 pupils had registered as smokers. They received advice and support and their parents were encouraged to involve the child's GP in treatments such as nicotine patches. Five smokers had already given up. The headteacher said he wanted to help those pupils who were already smoking and, by having a designated area, also allow pupils who did not smoke to use the toilets without having to inhale tobacco smoke.

Increasing the unit price of cigarettes

Hopkins and others (2001) demonstrated that increases in tobacco prices in the USA were associated with reduced levels of tobacco use by young people. It was estimated that a 10 per cent increase in product price would result in a 2.3 per cent decrease in the tobacco consumed by adolescents. These effects occurred among all ethnic groups studies, including vulnerable groups such as disadvantaged African-Americans and Hispanics.

Retail interventions to prevent cigarette sales to minors

Stead and Lancaster (2000) conclude that interventions can be effective in encouraging retailers to reduce tobacco sales to minors. However, simply giving information to retailers was less effective in reducing illegal sales than either active enforcement or multi-component educational strategies. Legislation alone was not sufficient to prevent tobacco sales to minors. Furthermore, the authors found limited evidence that reducing ease of access to tobacco had an effect on perceptions of smoking.

Reducing exposure to passive smoking

WHO (1999) suggests a combination of legislation and education to encourage behaviour change in adults in order to limit tobacco-smoke environments and hence reduce children's exposure to passive smoking. This would be a health promotion measure in itself and might also, as suggested earlier, reduce the likelihood of young people becoming resistant to tobacco smoke and taking up smoking.

Strategies, nonetheless, need to change awareness as evidence suggests that many parents do not appreciate the risks of passive smoking for their children. A poll conducted by SmokeFree London (MORI 2003) revealed a very low awareness of the impact of passive smoking on children. When

asked (without being given a list of possible responses) to give examples of the health impact of passive smoking on children, 26 per cent of parents identified asthma as a likely impact and 22 per cent mentioned respiratory illness or lung infections. However, two of the most common ailments linked to passive smoking – cot death and glue ear – were identified by only 3 per cent and 1 per cent of the parents, respectively. There is obviously a need to educate the public as to the serious risks linked to passive smoking.

A community initiative by Tyne and Wear health authority has demonstrated how such an approach can seem to have an impact. Leaflets and posters carrying the campaign strapline ‘Stub it out – there’s a kid about’ were distributed by midwives, health visitors and children’s departments of local hospitals, and advertisements were placed on the radio. An evaluation of the campaign found that it was associated with an apparent increased awareness of the impact of passive smoking with almost a quarter of smokers (24.2 per cent) indicating that they would consider protecting children from their, or other people’s, smoke in the future; and two-thirds of carers said they would actively avoid taking their children to smoky areas. In addition, 12 per cent of smokers reported that they were more likely to consider giving up smoking as a result of the campaign.

Smoking bans

There are many reasons for expecting that smoking bans might assist in reducing levels of smoking among young people. First, by restricting exposure to smoky environments, they may help to reduce children’s acclimatisation to tobacco. Second, they may place direct restrictions on the opportunities young people have for smoking and again help to break habits. And third, they help to create a negative social norm.

There is some evidence to support the effectiveness of bans. Wakefield and others (2000) found that greater restrictions at home, in public places and in school (where the ban is taken seriously and applied strongly) reduces the uptake and prevalence of teenage smoking.

National days

National days such as No Smoking Day in the UK have been shown to have important effects in raising awareness as well as acting as an ‘excuse’ to stop smoking. The No Smoking Day 2004 evaluation (ASH 2004d) found that 76 per cent of smokers in Great Britain were aware of the date of No Smoking Day. Of these, 41 per cent responded positively to it and 14 per cent made an attempt to give up. Nonetheless, the highest quit rates were among the group aged 45 to 54, and there is no evidence to suggest that the No Smoking Day had any specific appeal for young people.

Advertising and campaigning

Advertising and campaigning are important forms of communication that may be used either to encourage young people to smoke, or to get them to stop, or dissuade them from ever starting. Intervention strategies may, accordingly, be to reduce some kinds of promotional activity but to enhance others.

Tobacco advertising on television, newspapers and billboards has been banned in Britain for several years, but tobacco companies were still permitted to sponsor some sporting events until as recently as 2006. Sponsorship was particularly strong for the Formula One racing events and it is estimated that £70 million was spent in this way during 2001 (ASH 2004c). There is some suggestion that such advertising may have had an impact. Certainly Charlton and others (1997) found that boys whose favourite sport was motor racing were twice as likely as those that did not have an interest in the sport to become regular smokers.

Much of the advertising designed to deter young people from smoking has been of a 'shock factor' character. Nonetheless, this approach may sometimes backfire as Stretcher (1997) reports that smokers have been so shaken by the graphic images on these advertisements that they have automatically reached for a cigarette to calm their nerves. There is also suggestion that fear or shock campaigns can make people go into denial and try to escape and avoid the issues, convincing themselves that they have nothing to do with them (Wenzel and others 1997). It is debatable what effect other types of campaigns, such as writing anti-smoking messages on cigarette packets, are likely to have. Fischer and others' (1989) study of eye tracking indicated that young subjects often do not take in warnings even when clearly and intrusively printed on cigarette packets.

In his book, de Meyrick (2001) discusses the impact of campaigns to discourage smoking and highlights some of their inherent problems. She suggests that often they concentrate too much on health factors, which smokers already tend to be aware of, and that peer group influences and young people's belief that they are invulnerable, limit the impact of such advertisements. The most effective message, she believes, would be that adolescents can avoid nicotine addiction by not smoking. This is likely to be powerful because it suggests that smoking and cigarette addiction mean a loss of autonomy. Other messages could be that smoking means a loss of discretionary spending, manipulation by smoking companies, bad breath, and ageing effects on teeth and skin.

Some studies have attempted to evaluate the impact of campaigns on smoking behaviour among young people. A review of six studies (Sowden and Arblaster 1998) suggested that only two were associated with reductions in smoking behaviour. One found that a mass media campaign (which involved developing provocative messages that were used to cause affective personal reaction) was more effective than no intervention in influencing smoking behaviour. The other demonstrated that a mass media campaign combined with a school-based programme was more effective than a school-

based programme alone. Both of these studies also found statistically significant differences between the intervention and control groups in relation to immediate outcomes – such as attitudes to smoking, smoking norms, and intentions to smoke in the future, which are powerful mediators of smoking delay in young people.

On the basis of these findings, Sowden and Arblaster (1998) advocate that future mass media campaigns should build on the effective elements of existing campaigns, and that developmental work should be carried out with representative samples of the target audience to create media messages appropriate to that group. Campaign messages should be guided by theoretical concepts about behaviours and should be conveyed via media channels preferred by the target audience at the most appropriate time. Effective broadcasting campaigns need to have a sufficient intensity, frequency and duration, and the preference of the target audience for either radio or television is likely to depend on age.

An interesting and unusual advertising campaign, which aims to tell the truth about tobacco companies' manipulation and lies about the risk of smoking, has been developed in Canada. This tobacco industry denormalisation campaign was initiated so that young people rebel against the tobacco companies rather than health authorities (Lavack 1999). This campaign follows from the success of the truth® campaign in the USA, the largest national youth-focused anti-tobacco education campaign ever. It was designed to engage teens by exposing Big Tobacco's marketing and manufacturing practices, as well as highlighting the toll of tobacco in relevant and innovative ways. A key concept in the truth® campaign, as with Canada's campaign, is that youth's reason for using tobacco is rebellion, and the fact that tobacco kills makes it even more appealing to rebellious youth. The campaign, therefore, needed to make youth rebel against something else – and the ideal target for this rebellion was the duplicity and manipulation of the tobacco industry. Therefore, the truth® campaign uses edgy humour to highlight the manipulative tactics and techniques of the tobacco industry.

The truth® campaign website reports that 75 per cent of all 12- to 17-year-olds in the nation (21 million) can accurately describe one or more of the truth® campaign's advertisements, and that nearly 90 per cent reported that advertisements were convincing. Eighty-five per cent said the advertisements gave them good reasons not to smoke. Moreover, Monitoring the Future, one of the USA's most comprehensive substance abuse surveys, reported a dramatic decline in smoking among 8th, 10th and 12th graders (ages 13- to 17-years-old), with numbers of high school student smokers falling by more than one million between 2000 and 2002. The truth® campaign was cited as a factor in this public health success story.

4. Messages, key issues and the future role of NCB

It is clear that there is no simple way to prevent children and young people from taking up smoking, or to encourage them to stop once they have started, but there are, nonetheless, a number of activities, strategies and initiatives that could be worthwhile in reducing levels. This section draws attention to some of the strongest messages from this review and provides some pointers towards possible ways that NCB could become involved in this area. It is suggested that any such further work should include the participation of children and young people in all appropriate ways. Their perceptions of the critical issues, their insights into how young people think and behave, and their understanding of motives for smoking and giving up, are all crucial for the development of effective smoking prevention or cessation programmes.

Making a case

There is a very strong case for doing whatever possible to prevent young people from smoking and to help them to quit. The main arguments are as follows:

- The reduction of smoking among young people will have a knock-on effect on rates of smoking in adulthood. Less smoking overall will contribute to a healthier nation in the future, with fewer deaths attributable to cancer and other smoking-related diseases.
- Children who smoke are at particular risk of adverse health effects, partly due to the underdeveloped state of their lungs.
- Children and young people are often unaware of the addictive nature of smoking and once they have started may find it difficult to stop.
- Young people may think of themselves as invulnerable or too young to have to worry about the effects of smoking on their health. Trying to scare them by saying it will damage their health is not enough, and much more 'creative' approaches are called for.
- The more people that smoke, the greater the risks of passive smoking for everybody else – whether infants, children, young people or adults.
- There is general agreement that reducing smoking among young people is an important goal. There are increasing moves to outlaw smoking within the community but there could also be legislation to ensure that all schools are smoke-free zones.

Raising awareness

There needs to be greater awareness of problems, issues and services relating to smoking among young people, particularly the following:

- Raising parents' awareness of the very real impact of passive smoking upon children would seem to be particularly important. Not only are they

contributing to health risks among children, but they may also be indirectly influencing them to take up smoking themselves through providing role models and habituating them to tobacco.

- There needs to be much greater signposting to cessation services that are already available for young people.
- Interventions to prevent young people smoking, or to encourage them to stop, need to be more aware of and informed by knowledge of the activities and techniques that seem to work best.
- The use of young people's role models (whether real or imaginary) to raise awareness of the dangers of smoking might be explored further. Different approaches for boys and girls might be required.
- Anti-smoking advertising has failed to recognise the diversity in the population, including gender differences, and does not specifically target young people. It has also not been accompanied by other aspects of a comprehensive strategy.
- Strategies similar to the truth® campaigns in Canada and the USA have so far not been attempted on any scale in this country. Exploration of the feasibility and likely impact of such an approach could be worthwhile.

Prevention and cessation interventions

Some lessons have certainly been learned about prevention and cessation interventions that are most likely to meet with success. Here are some examples.

- Universal curriculum-based educational programmes are not sufficient to deter all young people from smoking. Education on smoking is provided within the science curriculum, but science lessons are not likely to be interactive, peer-led, or use methods effective in discouraging smoking. There is an expectation that education on smoking is included within the PSHE curriculum, but it is not obligatory and there is a lack of direction on how this might be done.
- Universal education-based programmes are not, in any case, effective on their own and need to be complemented by broader strategies. Social reinforcement and social skills-type programmes seem, nonetheless, to be more effective than traditional knowledge-based interventions – particularly for girls.
- Approaches that have met with better than usual success include peer-led prevention programmes, strategies including training in social skills to assist young people to resist pressures to smoke, and programmes involving parents.
- Due to the complex range of individual, social and environmental factors influencing decisions to smoke, multi-faceted approaches – involving education, health services, parents, social skills training, media campaigns, bans and enforced age restrictions in a range of settings – have been recommended.
- As in many other fields, there is a range of bodies setting standards and targets (for example, PCTs, National Healthy Schools, DATs) but with

little reference to each other. More joined-up working could increase effectiveness.

- Prevention is not just about education or about changing or influencing the behaviour of individuals. It is also about reducing the risk factors – such as deprivation, unhealthy lifestyles and school failure – with which it is linked, while at the same time enhancing protective factors.
- The truth® campaigns in the USA and Canada have met with considerable success and it would be instructive to examine further whether their approach would have a similar impact in this country. NCB might wish to explore the process in greater detail and develop a parallel strategy with a group of children and young people. If it were judged to be a feasible approach, a pilot developmental exercise might be carried out and evaluated to ascertain whether a subsequent and larger project seemed viable and valuable.

Policy

Consolidating the policy framework would strengthen resolve and processes to reduce rates of smoking among young people. Suggestions include the following:

- The *Smoking Kills* White Paper (Department of Health 1998a) centres attention on bans, advertising and NHS services. While these may be useful measures in themselves, a much more comprehensive approach to tackling smoking among young people is called for.
- There needs to be a much greater emphasis on young people within smoking strategies, together with the recognition that they are likely to need their own dedicated programmes and services. NHS services, for instance, are geared towards adults (when you call the helpline there are no specialist advisors for young people), which is significant given that cessation services for adults are generally thought not to be effective for young people.
- Smoking should be given a much stronger emphasis within programmes addressing drug misuse. The Public Performance Index for health, for instance, mentions only drug misuse and does not specifically refer to young people and smoking.
- Given the proven effects of passive smoking on children, there need to be clear policies to reduce smoking in general, smoking in public places, and smoking in schools and other children's settings.

Research

Finally, research has a part to play.

- There could be more longitudinal study of the impact of interventions to reduce smoking levels among young people.
- There is much reliance on survey evidence for clues as to why young people smoke, what may help them to stop, and how smoking may lead

to other drug use. More qualitative work in this area is called for (see, for example, Denscombe 2001a).

- A wide range of factors have been implicated for increasing the risk of smoking among young people and further evidence is needed to establish their respective impact. There is, for instance, a suggestion that young people from relatively deprived backgrounds are at particular risk. There is, however, no conclusive evidence on this question, and more knowledge of smoking patterns and the impact of interventions within different population groups (for example, by sex, age, social group, and ethnicity) would be valuable in enhancing understanding of why young people smoke (Blake and others 2001; Denscombe and Drucquer 2000). Attention should also be paid to exploring the role of self-identity in smoking behaviour (Lloyd and Lucas 1998; Charlton 2000). Knowledge in these areas would assist in targeting smoking strategies and programmes and in delivering appropriate interventions.
- Coleman and others (2000) suggest the need for an investigation into the reasons why young people are not being identified as a priority group by many smoking cessation services.
- Further examination of pregnant teenagers and young mothers who smoke, their reasons for smoking and the risk to their babies, could be a topic for future research. This should include consideration of smoking cessation services, such as a local Sure Start project, available to them.
- Another area for further investigation could be the provision and take-up of smoking services for young people with health problems, such as diabetes or asthma, where tobacco use is strongly discouraged.
- The risk of smoking appears higher among young people influenced by 'conventional risk factors' (Pierce and others 1996; Fleman 1997; Meltzer and others 2003) and it is, therefore, likely that particularly high rates would be found among groups of young people in custody, who are homeless, and so on, and that particular interventions may be called for. Ward (1998) identified young people looked after by social services as at increased risk of having or developing substance misuse problems. There is, nonetheless, a lack of research on the extent and nature of substance use among looked after young people. Preliminary analysis of a survey of youth offender institutions (Lewis, unpublished) suggests that aspects of practice that practitioners felt worked well to prevent and reduce smoking included: excellent collaboration between physical education and nursing staff; smoking cessation groups and nicotine replacement patches; acupuncture; access to age-appropriate promotional materials; and smoking cessation work within 'health fairs' where 'smokalisers' are used to encourage young people to test levels of carbon monoxide in their systems. Further investigation of smoking patterns and smoking interventions in different institutional and other settings could be valuable.
- Finally, research is called for to establish more clearly the role that smoking may play in young lives. The prevention of smoking in the first place is indisputably a prime goal. Encouraging young people to stop smoking, however, must be undertaken in the assurance that a coping

mechanism, or a means of promoting well-being, is not being removed without ensuring that something similarly effective is substituted in its place. This is an additional challenge for strategies addressing smoking behaviour among the young.

Conclusion

This review has highlighted that smoking prevalence among young people is a serious issue. While reports about smoking prevalence and cessation are plentiful, there is a lack of consensus on both the trajectories leading to smoking initiation and what should be done about it. There is also a lack of prioritising and awareness of this problem. Hence, despite some national activity by other organisations in this area, there is much scope for NCB involvement through awareness raising, advocating policy developments and change, proposing and/or initiating practice initiatives, and carrying out research. Activities and initiatives that involve young people themselves would seem particularly appropriate and important.

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Appendix: Relevant organisations

ASH – Action on Smoking and Health

102–108 Clifton Street
London EC2A 4HW

Tel: 020 7739 5902
Fax: 020 7613 0531
Email: enquiries@ash.org.uk
Internet: www.ash.org.uk

Public health charity, campaigning to reduce health problems caused by tobacco.

Action on Smoking and Health Scotland

ASH SCOTLAND
8 Frederick Street
Edinburgh EH2 2HB
Scotland

Tel: 0131 225 4725
Fax: 0131 220 6604
Email: ashscotland@dial.pipex.com
Internet: www.ashscotland.org.uk

Aims to alert the public to the dangers of smoking.

British Lung Foundation

73–75 Goswell Road
London EC1V 7ER

Tel: 020 7688 5555
Fax: 020 7688 5556
Internet: www.britishlungfoundation.org/

Provides information and support for all those living with lung disease and those living with them. Also funds scientific research into how to combat the illness.

British National Temperance League Freeway

Westbrook Court
2 Sharrow Vale Road
Sheffield S11 8YZ

Tel: 0114 267 9976
Fax: 0114 267 9976
Internet: www.bntl.org/

Aims to educate and encourage children and young people in the principles of total abstinence from alcoholic drinks; to preserve and safeguard the health of all persons and in particular young people who are in danger of becoming addicted to, or dependent upon, illegal drugs of any description, alcohol, solvents and other addictive substances. Offers web-based support and materials for Key Stage 1–3 teachers.

CLEANAIR

Campaign for a Smoke-free Environment
33 Stillness Road
London SE23 1NG

Tel: 020 8690 4649
Fax: 020 8690 4649
Internet: www.ezme.com/cleanair/

Seeks to restore the right to breathe clean air, free from unnecessary and avoidable pollution created by smoke from tobacco and other substances; to create a smoke-free environment for all to share and enjoy; to reduce the number of premature deaths from smoking, including passive smoking-related diseases.

Drug Education Forum

c/o Mentor UK
4th Floor
74 Great Eastern Street
London EC2A 3JG

Tel: 020 7739 8494
Fax: 020 7739 5616
Internet: www.drugeducationforum.com

The Drug Education Forum brings together national organisations from health, education, police and voluntary sectors that deliver or support the delivery of drug education. The Forum promotes the provision of effective drug education for all children and young people.

DrugScope

Waterbridge House
32–36 Loman Street
London SE1 OEE

Tel: 020 7928 1211
Fax: 020 7928 1771

Email: info@drugscope.org.uk
Internet: www.drugscope.org.uk

Formed by the merger of ISDD (Institute for the Study of Drug Dependence) and SCODA (Standing Conference on Drug Abuse). National coordinating body for voluntary organisations and agencies working in the drugs field. Aims to assist development of existing organisations and provide a forum for the exchange of information, by newsletter, regional meetings and so on. Comprehensive library, mail-order and enquiry services. Cooperates with other bodies to establish good practice in the provision of drug misuse information. Includes solvents. Locate/Resource-Net, a drug education and prevention information service on the same number, provides free information for professionals on out-of-school drug education and prevention activities and drug education resources for 11- to 25-year-olds in England.

National Healthy Schools Programme

Department of Health
Internet: www.healthyschools.gov.uk

Under the Wired for Health banner (which is a series of websites developed by the Department of Health and the Department for Education and Skills) this web resource provides guidance for following the National Healthy Schools Programme (that is, using the whole-school approach, etc.) as well as curriculum guidance related to health topics such as smoking.

National Heart Forum

Tavistock House South
Tavistock Square
London WC1H 9LG

Tel: 020 7383 7638
Fax: 020 7387 2799
Internet: www.heartforum.org.uk

Provides a forum for members to exchange information, ideas and initiatives on coronary heart disease prevention, in order to stimulate effective action.

National Institute for Health and Clinical Excellence (NICE)

MidCity Place
71 High Holborn
London WC1V 6NA

Tel: 020 7067 5800
Fax: 020 7067 5801
Internet: www.nice.org.uk

Having recently merged with the Health Development Agency, NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

No Smoking Day

59 Redchurch Street
London E2 7DJ

Tel: 0870 770 7909

Fax: 0870 770 7910

Internet: www.nosmokingday.org.uk

As well as organising, making people aware of, and getting the public involved in the national No Smoking Day, NSD aims to help people who want to stop smoking by creating a supportive environment for them. This is mainly achieved through highlighting, through their website, the many sources of help available to people who want to quit.

PSHE Subject Association

8 Wakley Street
London EC1V 7QE

Tel: 020 7843 1916

Fax: 020 7843 9512

Email: info@pshe-association.org.uk

Internet: www.pshe-association.org.uk

To raise the status, quality and impact of PSHE.

QUIT

National Society of Non-smokers
211 Old Street
London EC1V 9NR

Tel: 020 7251 1551

Helpline: 0800 00 22 00

Fax: 020 7251 1661

Email: info@quit.org.uk

Internet: www.quit.org.uk

Aims to help those who want to give up smoking.

Roy Castle Lung Cancer Foundation

200 London Road
Liverpool
Merseyside L3 9TA

Tel: 0871 220 5426

Fax: 0871 220 5427

Internet: www.roycastle.org/

Dedicated to defeating lung cancer. It is involved in campaigning for smoking bans in public places, as well as advocating more focus on the prevention of smoking uptake among young people. The Foundation's manifesto outlines a series of practical recommendations for changes to healthcare services and government policy.

Tobacco Manufacturers' Association

5th Floor
Burwood House
14–16 Caxton Street
London SW1H 0ZB

Tel: 020 7544 0100

Fax: 020 7544 0017

Email: information@the-tma.org.uk

Internet: www.thetma.org.uk

The TMA represents the views of its principal member companies and provides factual information on behalf of the UK industry as a whole. The TMA defends the legitimate interests of its member companies and the freedom of adults to make an informed choice about whether or not to smoke.