National Social Marketing Centre
Scoping Report

Lewisham PCT
Evelyn Ward

Smoking

June 2007

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Contents

Executive Summary

1. Smoking in the UK

Around 10 million adults smoke cigarettes in Great Britain: this is about a quarter of the population. About half of all regular cigarette smokers will eventually be killed by their addiction. Every year, around 114,000 smokers in the UK die from smoking related causes (ASH). In 2005, 26% of men smoked and 23% women in the UK.

The GHS has consistently shown that cigarette smoking is more prevalent among people in manual occupational groups than those in non-manual groups. In England in 2005, 29% of those in manual occupational groups were cigarette smokers.

2. Repercussions of smoking

Smoking harms nearly every organ of the body, causing many diseases, and reduces quality of life and life expectancy. It has been estimated that, in England, 364,000 patients are admitted to NHS hospitals each year due to diseases caused by smoking. For every death caused by smoking, approximately 20 smokers are suffering from a smoking related disease.

One in two long-term smokers will die prematurely as a result of smoking – half of these in middle age. The most recent estimates show that around 114,000 people in the UK are killed by smoking every year, accounting for one fifth of all UK deaths.

According to ASH[1], there is sufficient evidence to suggest conclude that exposure to tobacco smoke increases asthma symptoms and attacks both for smokers and for non-smokers.

The link between smoking and stress is well documented and smokers often deal with stress by lighting a cigarette. However, the relief only lasts a short time. Soon the stress will return and the smoker will need another cigarette.

ASH[2] tells us that many epidemiological studies have reported an association between clinical depression and smoking. Some have concluded that the effects of long-term nicotine exposure on the brain may have a causal influence on major depression while others suggest that shared environmental or genetic factors may predispose to both smoking and major depression.

3. Targets

2005/8 4 week quitters 5867 (60 stretch)
2005/8 52 week quitters 1760 (18 stretch)

2005/6 4 week quitters 2114 (no stretch)
52 week quitters 634
2006/7 4 week quitters 1604 (30 stretch)
52 week quitters 481

2007/8 4 week quitters 2149 (30 stretch)

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[1] ASH *Online* [http://www.ash.org.uk/html/passive/html/asthma.html].
[2] http://www.ash.org.uk/html/factsheets/html/fact15.html

52 week quitter 645

The PCT has exceeded its stop smoking target of 1574 for 2006/7. This is the first time they have ever got beyond a red rating. This means the PCT will get a green rating from NHS London for this level of performance.

4. The smoking ban

It is known that ending smoking in workplaces is a simple and cost-effective way to encourage smokers to quit. Wanless reported to the UK Government that "A number of other countries have now implemented a workplace smoking ban via legislation. Some of this experience has been shown to be successful in reducing the prevalence of smoking".

54% of the UK population reportedly strongly support the smoke free law. Evidence from Scotland and the Republic of Ireland suggests the English smoking ban will have significant positive effect over smoking rates.

5. Introduction to social marketing and evidence for its potential

Hastings (January 2007, unpublished)[3] explains that developments in public health show that engaging with social marketing to change voluntary behaviour "is not only desirable, but a matter of life and death. We are now entering an era when chronic, lifestyle related illnesses are a greater risk to life and limb than the more familiar communicable killers of yesteryear… In this climate, insights into how behaviour can be influenced are at a premium; our very lives depend on them".

Social marketing is an approach to behaviour change that uses commercial marketing techniques to change behaviours for the social good. Commercial marketers have had decades of success in changing our behaviours and evidence suggests that social marketing ideas and techniques can successfully modify patterns of exercise, drinking, smoking and drug use and other behaviours. Like marketing, social marketing requires rigorous consumer insight in order to be successful.

6. Strategic considerations of social marketing include:

- Upstream or downstream? Social marketers must weigh up the pros and cons of spending their budget on upstream or downstream interventions.
- Prevention or reaction? Prevention may be a viable behavioural goal for social marketers and should be carefully considered.

7. Clients

a. Lewisham:

Lewisham is 66% white and the largest BME group being Black or Black British. 7 of Lewisham's 18 wards are the most deprived in England. Life expectancy is lower in Lewisham than for England. Smoking has a 33% prevalence in Lewisham.

b. Evelyn:

[3] Hastings, G (January 2007) The new diaspora has already begun

Evelyn is the most deprived ward in Lewisham. Evelyn has a higher than average social dependency ratio, reflecting the high numbers of children in the ward.

The BME population comprises 54.8% of Evelyn's resident population[4], compared with an average of 34% across the borough. The largest single BME populations are Black African (25.1%) and Black Caribbean (10.4%). Other ethnic groups include Vietnamese, Somalians, Nigerians, Kenyans and Chinese. After Christianity, the most popular religion in Evelyn is Islam.

- Few people own their own home in Evelyn.
- Many are unemployed or long-term sick.
- Nearly 30% of Evelyn residents have no qualifications.
- Most employed people are in manual or routine occupations.
- Long-term unemployment and youth unemployment are problems
- Life expectancy is lower than average.

Evelyn has many towerblocks and social housing, although some significant regeneration has been undertaken in the last decade.

Evelyn has an overall smoking rate of 42%. The male smoking rate is 49% and the female smoking rate is 35%. Evelyn has the highest smoking rate in Lewisham. A significant number of Evelyn and N1's health problems can be linked to smoking.

8. Smoking cessation

a. National:

- In 2005, 40% of smokers were offered help or advice to stop smoking by someone at their GP surgery
- From April – Sept 06, 51% of those setting a quit date successfully quit. This figure increases with age.
- Most people quit using NRT
- 51% of pregnant women who set a quit date successfully quit

b. Lewisham:

- N1 had a considerably lower quit success rate than the other neighbourhoods in 2004/5.

Level 2 service summary

- In 2005, success rate was 41%
- Women set far more quit dates than men
- 80% of quit dates set were by the White population
- The Mixed group has the highest quit rate, the White population the lowest
- There was considerable variation amongst the wards
- Few pregnant women set quit dates

Level 3 Service Summary

- Between April 01 – Mar 05, there was a 67% success rate
- Slightly more females set quit dates than men
- Highest number of quit dates were set by the White population
- The Asian population had the highest quit success rate

[4] Evelyn, a ward profile: Summary of information.

- Evelyn, New Cross, Blackheath and Bellingham had the lowest number of quit dates set.

c. Evelyn:

In 2006 (Jan to December) 166 smokers accessed the smoking cessation services in Evelyn. 75 of these were successful quits (45%) and 91 unsuccessful. 99 smokers accessed cessation services via their GP. 44 accessed cessation services via a pharmacy.

The data available suggests that:

- The Walk In Centre had the most attempts and successes in 2006/7
- The Waldrum had many attempts in 2005/6 but far fewer in 2006/7.
- The Grove had many more attempts in 2006/7 than 2005/6
- Overall the GP practices had fewer attempts than the pharmacies.

1. By far the largest proportion of people accessing Evelyn smoking cessation services come from the White ethnic group (68%). Black African and Caribbean smokers follow this (14%) with Asian smokers having accessed the services the least (2%). There were no Chinese people accessing the service in 2006.
2. 89 women accessed smoking cessation services in 2006 compared with 77 men. More men smoke than women in Evelyn, so this statistic also suggests that for an unknown reason men are not accessing the services as much as women.
3. The largest age group accessing smoking cessation services from Evelyn are the 35-44 year olds
4. There were no pregnant smokers seen by any smoking cessation service in 2006.

9. Behavioural influences

a. Theory:

- It is likely that the social norm in Evelyn is to smoke.
- Working class social capital emphasises social norms so makes it harder to overcome cultural barriers to cessation. Evelyn residents may be fairly isolated and have strong bonding but limited bridging social capital.
- Perceived self-efficacy is required to change difficult behaviours. It is likely that PSE amongst Evelyn residents is low.
- Perceived control over health is required to give up smoking and it may be that Evelyn residents have limited perceived internal control. This could be due to disempowerment from unemployment, routine occupations, low income and poor housing.
- A tendency to think about the future is important for making health-related changes such as cessation and a correlation between seldom thinking about the future and low socio-economic status is known. It may be that Evelyn residents seldom consider the future.

b. Socio-economic:

- Smoking is often seen as a way of coping with the hardship that comes from deprivation. This may be the case in Evelyn too.

- It is known that men and women with at least O level qualifications were less likely to be current smokers than those without qualifications. Given the limited education level of many Evelyn residents, this is likely to have considerable implications.

c. Demographic

- Stopping smoking is a new phenomenon in many BME groups and cultural and linguistic barriers may impair access of people from these groups to health information and advice. Evelyn has a 55% BME population.
- BME groups may not access cessation services due to linguistic or cultural reasons rather than from a lack of desire to quit.
- Willpower and the advice of family and friends may often be relied upon over the advice of professionals or NRT.
- Men tend to smoke more heavily than women but women tend to be more reliant on cigarettes and although set more quit dates are less successful at quitting.
- There is a dangerously high smoking prevalence amongst men in Evelyn.
- Men tend to rely on willpower whereas women are more likely to seek professional advice.

d. Competition to behavioural goal

Potential competing factors to smoking cessation for Evelyn smokers	
Competing factor	**Potential required actions**
Smoking is a facet of working class culture	Culture change (very difficult and often taking generations)
Smoking as a coping strategy for stress	Assess and adjust stress-making situations (poor housing tenure, unsafe environment, economic hardship) and support residents in their ability to cope with stress
Smoking as a social pleasure	Provide healthier options for leisure time and information and support to encourage use.
Image of smoking. To some degree, and particularly to teenagers, smoking may still have the image of being 'cool' and adult.	Provide non-smoking role models and counter the culture of 'cool' promoted by tobacco companies. Present the concept that teenagers are being manipulated by commercial marketers.
Cultural norms	In addition to working class cultural norms, members of BME groups will also face cultural and religious barriers to cessation. Smoking for men in the Bangladeshi culture, for example, is by far the norm, suggesting that cessation for Bangladeshi men will have additional barriers.
Gender norms	Men and women smoke for different reasons and in different ways. Smoking is a very public behaviour and there may be considerable barriers for men, for example, in quitting when their pub and drinking culture is inextricably linked to smoking.

10. Intervention review

A full review of interventions includes

- General intervention review
- NICE report into behaviour change

- Interventions for BME groups
- Interventions for deprived communities
- Case studies
- Prevention intervention review

Where the information is available, results and evaluative notes are also given. The conclusion reached is that a combination of advice directed at individuals and pharmacological treatments is the most successful formula.

11. Review of potential stakeholders

A list and description of potential stakeholders is included. Conversations with each are described and the final analysis shows stakeholders who are keen to be involved and those with reservations:

It is important to have support from local well established groups when instigating a social marketing initiative. The following table summarises support which these conversations have suggested is available:

Full support offered	
Sandra Franklin	Mornington Surgery
Jennifer Taylor	Town Centre Manager
Dave Westmore	Clyde Street Early Years Centre
Ian Schlazer	Lockyer's Pharmacy
Valerie Pusey	Grove Medical Centre
Des Malone	Deptford Community Forum
Gayle Wallace	Lewisham Neighbourhood Panel
Rebecca Algar	QUIT
Amanda Gosling (replacement)	Lewisham Community Development Partnership
Dr Louise Irvine/ Jackie O'Brien	The Waldrum
Eve Williams and Tracey Smithers	Community Drug Education Project
Doug Elsley	John Evelyn Public House
Joan Barker	Riverside Youth Club
Linda Nash	REETA
Miriam Long	Voluntary Action Lewisham

Possible support: 'keep in the loop'	
Aleah Kamruddin	Building Healthier Communities
Arnie Andrews and Beverley Smith	Community Opportunities Service

Interest which could be developed	
-	Federation of Refugees from Vietnam
Dr and Mrs Batra	Waldrum Medical Centre
Nga Ndio	FORVIL
My Tang/Phung	Deptford Vietnamese Project
	Clifton Rise

Dr Hashmi	Dr Hasmi (GP)

Not interested at this stage	
Bing Khakwani	Kingfisher Medical Practice
Dave Watts	190 Advice Centre

Possible support but not able to get in touch	
Claudia Reid and Mark Simons	Deptford Green School
Ann O'Connor	Wavelengths
Conroy St. Hilaire	2000 Community Action Centre
	Evelyn Childhood Centre
Dental practices (Evelyn Street and Deptford High Street)	
Churches	

12. Initial segmentation

The following different segments are identified and justified. Stakeholders who should be engaged are identified:

	Potential segmentation	Justification	Possible stakeholder group	Opinion
1	Men aged 35-44.	• 49% of men smoke and 35% women. • 35-44 year olds access local cessation services the most.	None in particular. Community Forum and Neighbourhood Panel may be of use as may the John Evelyn pub and VAL	This is a good group to target, but without the added segmentation of ethnicity it may be difficult to effectively target the intervention.
2	Asthma sufferers	N1 has the highest asthma hospital admission rate in London and twice the national rate.	• Mornington Grove • Lockyer's • Waldrum (Batra/Irvine)	Asthma may be a good link into a segment. Asthma sufferers will benefit from quitting and could easily be accessed from GP data if it were permitted.
3	Parents of asthmatic children	As above	• As above • Clyde Street children's centre • Deptford Green School • Evelyn Early Years Centre	Parents will be concerned that their smoking will effect their children and this could be used as the basis for an intervention
4	Smokers with children	Anecdotally there is much concern amongst parents that their smoking will damage their children's health.	• As above	

5	Adults in routine employment	There was much anticipation of the forthcoming smoking ban and an expectation that quit attempts will increase.	• Waldrum • Mornington • Grove • Lockyer's • QUIT • Lewisham Community Development Partnership • John Evelyn pub • VAL	Employed residents of Evelyn tend to work in catering, which traditionally has long hours and poor conditions. There are also numerous people in manual employment which is a hotbed for smoking. These workers will be effected by the ban and offering the right encouragement and messages may improve smoking cessation rates dramatically.
6	Vietnamese men	Many Vietnamese men smoke yet no Vietnamese people saw a smoking cessation advisor in 2006. Smoking is an integral part of Vietnamese culture.	• FORVIL • Deptford Vietnamese Project • Federation of Refugees from Vietnam • REETA	This segment is not low hanging fruit. Vietnamese men clearly do not desire to give up. The behavioural goal may have to be increasing intention to quit rather than increasing quit attempts and rates. The language barrier is significant, also, although Vietnamese community workers such as Alex Hopkins may overcome this.
7	Bangladeshi and Indian men	Again, many Bagladeshi and Indian men smoke but are unwilling to give up	• Lockyer's Pharmacy • Possibly Grove and Mornington • Waldrum • QUIT • REETA	This segment again is not low hanging fruit and considerable work would have to be done to gain the trust of the group. There are no specific stakeholder groups identified who could support an intervention targeting this group.
8	Somali men	Many Somali men smoke.	• Lockyer's Pharmacy • Possibly Grove and Mornington • Waldrum • QUIT • The Somali Project • SEDEC • REETA	Anecdotally there are far more Somali women than men in Evelyn. Many arrive as asylum seekers. The previous project targeting this group had little success but QUIT have written a full report and could be useful stakeholders if this was considered a target group. Several community workers have commented that smoking is not a considerable problem in the Somali community, although chewing tobacco is.

9	Established refugees	New refugees are more concerned with learning English, finding accommodation and getting to grips with benefits and welfare systems. Learning that England has a culture of quitting smoking may well be too much to handle for new refugees. Establish refugees, however, are involved with seeking employment and becoming valued members of the community. They may be susceptible to an intervention as part of this process	• LCDP • Building Healthy Communities • Deptford Green School • Clyde Street Childrens Centre • REETA • Community Drug Education Project	This group may be too large to target effectively. However, refugees who are accessing services to better integrate into the community (childcare, employment, training, health advice) may also be 'contemplators' for improving their own health and believe they can make a positive change to their smoking status. Cultural barriers between groups may prevent an intervention having real impact, however.
10	Muslims	Muslims celebrate Ramadan, which involves fasting from dawn until dusk for a month. Interventions have been run in the past to encourage smoking cessation to become part of the Ramadan ritual of fasting	• DCF • LNP • Deptford Green School	There is a danger that overcompensation occurs during Ramadan, ie. smokers binging after nightfall. However, this seems like an ideal time to target this group. The Muslim population of Evelyn is large, with Asian, Somali and some Eastern European members.
11	Pregnant women	No pregnant women from Evelyn accessed any smoking cessation service in 2006.	• Deptford Green School • Clyde Street Early Years Centre • Grove • Mornington • Lockyer's • Waldrum • Surestart/Evelyn Early Years Centre • VAL	There is considerable evidence that interventions targeted specifically at pregnant women can have significant success.
12	Young people	There are a disproportionately high number of young people in Evelyn.	• Deptford Green School • Riverside Youth Club • Milbrook Youth Club • Police initiatives	A prevention intervention may be viable.

However, the 6 segments considered to be the most accessible and practical are:

- Parents of asthmatic children
- Parents
- Vietnamese men
- Muslims
- Pregnant women
- Young people

13. Recommended further research

Some research is available into the attitudes and beliefs of the main segments. However there are considerable gaps. For each of the recommended segments research recommendations are made. In most cases, qualitative research comprising interviews and focus groups is recommended. Where language is a problem, these interviews should be conducted in the first language of the interviewees.

Questions to ask during the qualitative research stage include:

Parents with asthmatic children

a. What are the key emotions surrounding the issue of smoking around the asthmatic child?
b. Is there a knowledge gap regarding the link between smoking and asthma?
c. What are the key barriers to cessation or attempted cessation?
d. What are the parent's opinions and feelings about (as well as experiences of) current cessation services?
e. What form of service would be the most supportive for this group?

Parents

a. What are the key emotions surrounding the issue of smoking around children?
b. Is there a knowledge gap regarding the danger of passive smoking for children?
c. What are the key barriers to cessation or attempted cessation?
d. What are the parent's opinions and feelings about (as well as experiences of) current cessation services?
e. What form of service would be the most supportive for this group?

Vietnamese men

a. What are the cultural connotations with smoking?
b. What is the relationship between smoking and masculinity in Vietnamese culture?
c. What are the key barriers to smoking cessation?
d. How would smoking cessation advice best be delivered?
e. What are the experiences and opinions of current services?

Muslims

a. What are the religious and cultural connotations with smoking?
b. What are the feelings towards long-term abstinence in terms of religious belief?
c. What are the possible implications of the Ramadan fast on smoking cessation?
d. What are the opinions and experiences of current cessation services?
e. What would the ideal support be for quitters during Ramadan?

Pregnant women

a. What are the key emotions regarding smoking whilst pregnant?

b. What are the key barriers to cessation for pregnant women smokers in Evelyn?
c. What are pregnant women's opinions and experiences of cessation services available
d. What would the ideal support be for cessation?

Young people

a. What is life like for young people in Evelyn?
b. What are the pressures to smoke and barriers to cessation?
c. What is the youth culture surrounding smoking?
d. What are the young people's opinions of current cessation services?
e. What kind of service would most appeal?

Where it will benefit the research to have a fully representative view of current services or opinions, quantitative research in the form of a postal survey may be used. In the case of the Vietnamese population, previous research within this community has highlighted their preference for face-to-face communication over writing or telephone so a quantitative phase is not recommended using these methods.

The ethics of discussing an individuals health, gaining access to health records or personal information or discussing an illegal behaviour must be carefully considered and an ethics committee may need to be approached.

13 Next steps

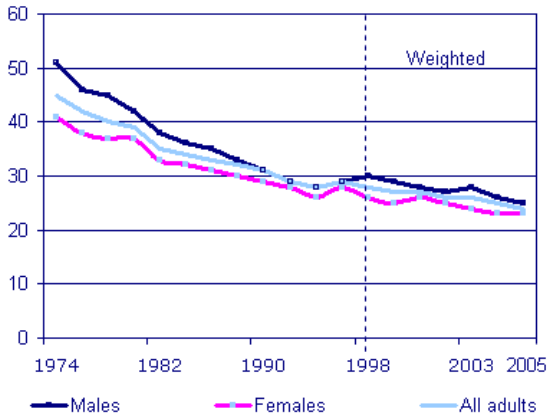
The following next steps should be made towards developing the social marketing intervention:

- ✓ Discussion with Lewisham PCT to finalise target group, behavioural goals and timescales and to identify key stakeholders.
- ✓ Discussion with key stakeholders to define their level of involvement and interest
- ✓ Dissemination of scoping report findings to key stakeholders and broader interested group
- ✓ Discussion of primary research strategy and research questions with key stakeholders
- ✓ Primary research conducted and analysed
- ✓ Dissemination of primary research to key stakeholders and broader interested group
- ✓ Brainstorming to generate initial ideas for intervention with a focus on the possible exchange and theoretical base
- ✓ Generate broad plan for intervention, including evaluation methodology
- ✓ Make internal changes where required, in line with stakeholders
- ✓ Invite external agencies to pitch for marketing communications work
- ✓ Implementation
- ✓ Evaluation
- ✓ Follow up

1.0 Smoking in England

Around 10 million adults smoke cigarettes in Great Britain: this is about a quarter of the population. About half of all regular cigarette smokers will eventually be killed by their addiction. Every year, around 114,000 smokers in the UK die from smoking related causes (ASH).

1.1 Trends



Percentage of adults who smoke cigarettes by sex: Great Britain 1974 to 2005

The prevalence of cigarette smoking decreased substantially in the 1970s and early 1980s, from 45% of all men and women aged 16 and over in 1974 (51% of men and 41% of women) to 35% overall in 1982 (38% of men and 33% of women). Prevalence continued to fall until 1994, where it reached a plateau until 2000. Since then it has fallen again to 27% for men and 25% for women in 2002 and further still to 26% for men and 23% for women in 2005.

2005 national smoking rates
Men: 26%
Women: 23%

Most of the decline in consumption in the 1990s was due to a reduction in the proportion of heavy smokers. The proportion of respondents smoking on average 20 or more cigarettes a day fell from 14% of men in 1990 to 11% in 1998, and from 9% to 7% of women over the same period. It has since remained virtually unchanged among both men and women.

Filter cigarettes continue to be the most widely smoked type of cigarette. However, there was an increase in the 1990s in the proportion of people smoking hand-rolled cigarettes. Among men the proportion increased from 18% in 1990 to 33% in 2002. Among women it increased from 2% to 13% during the same period. This increase may be partly due to the rising price of packaged cigarettes and the reduction of tar yield in packaged cigarettes (hand-rolled may be made with a higher tar yield).

A decline in the prevalence of pipe and cigar smoking among people aged 16 and

over has been evident, with most of the decrease occurring in the 1970s and 1980s. The proportion of men smoking pipes fell from 12% in 1974 to 6% in 1986 and in 2002 it was 1%. The proportion of men smoking at least one cigar a month more than halved from 34% in 1974 to 16% in 1978. By 2002 it had reduced to 5%. Only 3% of women smoked cigars in 1974, and since 1978 the proportion of women who smoke cigars has scarcely been measurable by the GHS.

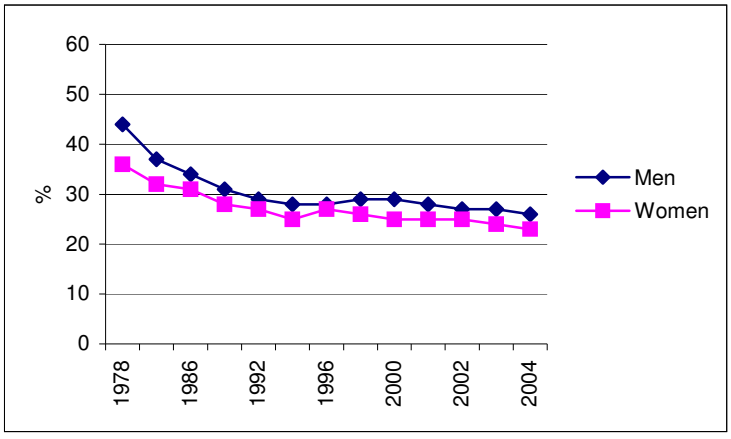
The general smoking trend is on our side. In 2003/04 two thirds (66%) of cigarette smokers in Great Britain said that they wanted to give up, though 55% said it would be difficult to go without smoking for a whole day.[5] There has also been an increase in the proportion of men and women aged 16 and over who have never smoked a cigarette. Among men, the proportion never having smoked rose from 25% in 1974 to 46% in 2002. The increase in the proportion of women who have never smoked has been smaller, from 49% in 1974 to 54% in 2002.

In 2003/4, 66% of cigarette smokers in Great Britain wanted to give up

1.2 Gender

Although men are still more likely than women to smoke cigarettes, the gap has narrowed.

Prevalence of cigarette smoking by sex: 1978 to 2004. Adults age 16 and over, England



In 1974 51% of men and 41% of women smoked (GHS 2004/05: DoH summary)[6]. In 2005, 25% of men and 23% of women were cigarette smokers.

In recent years there has been a significant drop in the proportion of men aged 16 to 19 smoking cigarettes (from 30% in 2000 to 22% in 2002). Women aged 16 to 19 were significantly more likely to smoke cigarettes than men in this age group, with 29% smoking in 2002.

[5] Adapted from: GHS 2004/05: DoH summary 2005
[6] The New Consumer Agenda – a public debate. National Consumer Council.

The proportion of men who were heavy smokers (on average 20 or more cigarettes a day) fell from 14% in 1990 to 10% in 1998. Among women the proportion fell from 9% to 7% over the same period. Since then the proportions have remained virtually unchanged.

The proportion of light to moderate smokers (on average under 20 cigarettes a day) has been around 17 to 19% of both men and women since 1998. Among men and women, on average men smoked 15 cigarettes a day and women smoked 13 a day in 2003/04.

1.3 Age

Cigarette smoking is still more common among adults aged 20 to 34 than other age groups. In 2003 36% of adults aged 20 to 24 and 34% of adults aged 25 to 34 were smokers compared with 15% of those aged 60 and over.

Cigarette smoking is still most common among adults aged 20-34.

Since 1974, the greatest percentage decrease in the proportion smoking has been among people aged 60 and over, where the prevalence has more than halved from 34% to 15% in 2002. However, this reflects the fact that people in this age group are more likely to have been regular smokers in the past who have given up.

Over 80% of smokers start as teenagers. In the United Kingdom about 450 children start smoking every day. In England one fifth of 15 year olds are regular smokers: 16% of boys and 25% of girls (ASH *Online*).

1.4 Pregnancy

The GHS for 2001 showed that 19% of pregnant women smoked throughout their pregnancy with 39% smoking under 20 and only 12% smoking over 35 in pregnancy. Smoking was particularly prevalent among women who were single, separated for divorced (55.5%); classed in social groups DE (52.2%); lived in rented local authority accommodation (57.3%); and who had left full time education at 15 or 16 years old (52.9% and 42.7% respectively) (Miller, 2006).

1.5 Ethnic Groups

The 1999 Health Survey for England reported the self reported cigarette smoking prevalence for men and women by minority ethnic group (Miller, 2006):

Minority Ethnic Group	Men	Women
Bangladeshi	44%	1%
Irish	39%	33%
Black Caribbean	35%	25%
Pakistani	26%	5%
Indian	23%	6%
Chinese	17%	9%

1.6 Smoking in the South East

Smoking rates vary by region. ASH claims that in London and the South East 22% of adults smoke whereas the Government Office for the South East claims that about 26% of adults currently smoke in the region with more than 16,000 people are dying from smoking each year. It is estimated that in the South East, every day, nearly 22 million cigarettes are smoked.

In the North East the rate is 29%. In Scotland 27% of the population smoke In Wales the rate is 22% (ASH, *Online*). Smoking rates in the South East have not declined over the past few years and 16% of all deaths are due to smoking[7].

The following costs are given by the Government Office for the South East to the regional economy:

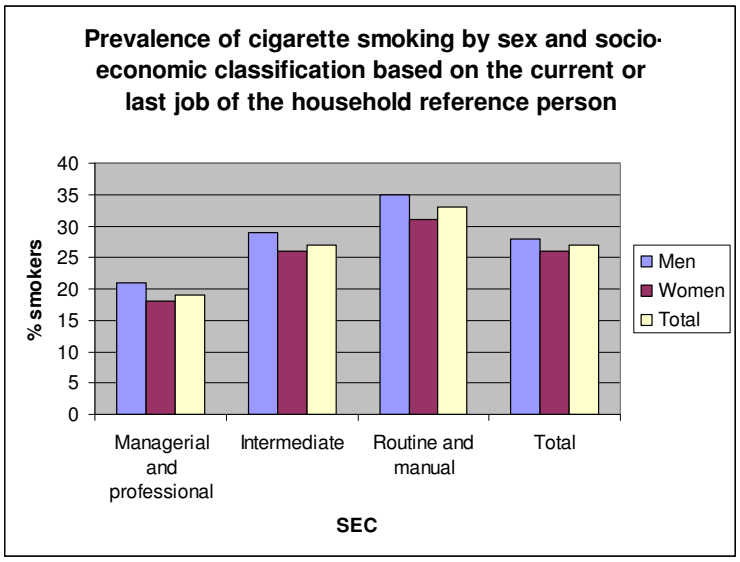
Impact of smoking	**Cost**
Hospital admissions	£238.5m
Premature deaths	£193m
Outpatient appointments	£38m
Business cost of hospital time	£6m
Second hand smoke	£4m
Other sick days	£370m
Working day smoking	£1.2b
Spend on tobacco	£14m
Stopping smoking services	£5m
Prescription cost attributable to smoking	£96.8m
Fires caused by smoking	£15.5m
Total cost	£2.2b

1.7 Smoking and socio-economic status

The GHS has consistently shown that cigarette smoking is more prevalent among people in manual occupational groups than those in non-manual groups. In England in 2005, 29% of those in manual occupational groups were cigarette smokers, compared with 33% in 1998. This is a considerable decrease. However In 2002, 20% of those classified as non-manual workers smoked cigarettes, compared with 31% of those classified in the manual group.

The graph below shows the prevalence of cigarette smoking in 2001 in relation to socio-economic status. There are striking differences between the various classes. Prevalence was lowest among those in higher professional and higher managerial households (15% and 16% respectively) and highest, at 35%, among those whose household reference person was in a routine occupation.

[7] http://www.go-se.gov.uk/gose/publicHealth/improvement/tobaccoControl/)



Source: Office of National Statistics

In general, the economic burden of smoking weighs heaviest on the poorest. Smoking further impoverishes people who are already poor and hikes in cigarette costs do not deter this group from smoking but deprive them of other essential products.[8]

It is estimated from the Family Expenditure Survey (FES) that in 1998/99 the average household spent around 1.5% of their weekly income on tobacco products. Among the poorest households however, it is estimated that around 15% of weekly income is devoted to purchasing cigarettes The Independent Inquiry into Inequalities in Health reported that:

> "Studies of the cost of meeting basic needs, which explicitly exclude spending on tobacco, indicate that Income Support levels are insufficient to secure a basic but adequate standard of living, especially if the households contain children. Not surprisingly therefore, low income households where parents smoke are much more likely to be lacking basic amenities, including food, shoes and coats than non- smoking parents on Income Support"

Lone parents living in rented accommodation and relying on social security benefits were found to have smoking levels in excess of 75% in one study (Dorsett and Marsh, 1998) and The Health Survey of England 2003 stated that there was a marked tendency for cigarette smoking prevalence to increase as equivalised household income decreased.

In 1996, smoking accounted for over half the difference in risk of premature death among men between social classes while between 1991-1993 premature deaths from lung cancer were five times higher among men in unskilled manual work compared to those in professional occupations.[9]

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[8] Crosier, A; (Feb 2001): A rapid mapping study of smoking projects and services targeted at people living on low income and/or minority ethnic group. *Report to the Health Development Agency*

[9] Miller, J (2006). Are Lewisham Stop Smoking Services reducing inequalities in Health?

2.0 Repercussions of smoking

2.1 Illness

Tobacco contains over 4,000 chemical compounds, present as either gases or as tiny particles. These include carbon monoxide, arsenic, formaldehyde, cyanide, benzene, toluene and acrolein.

Smoking harms nearly every organ of the body, causing many diseases, and reduces quality of life and life expectancy. It has been estimated that, in England, 364,000 patients are admitted to NHS hospitals each year due to diseases caused by smoking. This translates into 7,000 hospital admissions per week, or 1,000 day. For every death caused by smoking, approximately 20 smokers are suffering from a smoking related disease. In 1997/98, cigarette smoking caused an estimated 480,000 patients to consult their GP for heart disease, 20,000 for stroke and nearly 600,000 for COPD.

Half of all teenagers who are currently smoking will die from diseases caused by tobacco if they continue to smoke. One quarter will die after 70 years of age and one quarter before, with those dying before 70 losing on average 21 years of life. It is estimated that between 1950 and 2000 six million Britons, 60 million people worldwide, died from tobacco-related diseases.

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Many medical conditions associated with smoking may not be fatal but may cause years of debilitating illness or other problems. These include:

Increased risk for smokers	
Acute necrotizing ulcerative gingivitis (gum disease)	Muscle injuries
Angina (20 x risk)	Neck pain
Back pain	Nystagmus (abnormal eye movements)
Buerger's Disease (severe circulatory disease)	Ocular Histoplasmosis (fungal eye infection)
Duodenal ulcer	Osteoporosis (in both sexes)
Cataract (2 x risk)	Osteoarthritis
Cataract, posterior subcapsular (3 x risk)	Penis (Erectile dysfunction)
Colon Polyps	Peripheral vascular disease
Crohn's Disease (chronic inflamed bowel)	Pneumonia
Depression	Psoriasis (2 x risk)
Diabetes (Type 2, non-insulin dependent)	Skin wrinkling (2 x risk)
Hearing loss	Stomach ulcer
Influenza	Rheumatoid arthritis (for heavy smokers)
Impotence (2 x risk)	Tendon injuries

Optic Neuropathy (loss of vision, 16 x risk)	Tobacco Amblyopia (loss of vision)
Ligament injuries	Tooth loss
Macular degeneration (eyes, 2 x risk)	Tuberculosis
Function impaired in smokers	
Ejaculation (volume reduced)	Sperm count reduced
Fertility (30% lower in women)	Sperm motility impaired
Immune System (impaired)	Sperm less able to penetrate the ovum
Menopause (onset 1.74 years early on average)	Sperm shape abnormalities increased
Symptoms worse in smokers	
Asthma	Graves' disease (over-active thyroid gland)
Chronic rhinitis (chronic inflammation of the nose)	Multiple Sclerosis
Diabetic retinopathy (eyes)	Optic Neuritis (eyes)
Disease more severe or persistent in smokers	
Common cold	Pneumonia
Crohn's Disease (chronic inflamed bowel)	Tuberculosis
Influenza	

(ASH *Online*).

2.2 Deaths

One in two long-term smokers will die prematurely as a result of smoking – half of these in middle age. The most recent estimates show that around 114,000 people in the UK are killed by smoking every year, accounting for one fifth of all UK deaths. Most die from one of the three main diseases associated with cigarette smoking:

- lung cancer
- chronic obstructive lung disease (bronchitis and emphysema)
- coronary heart disease.

The table below shows the percentage and numbers of deaths attributable to smoking, based on the 2002 data.

Estimated percentages and numbers of deaths attributable to smoking in the UK by cause
(based on 2002 mortality data)

	Deaths from disease estimated to be caused by smoking					
	Number			As% of all deaths from disease		
	Men	**Women**	**Total**	**Men**	**Women**	**Total**
Cancer						
Lung	18002	10032	28034	89	75	84
Upper respiratory	525	85	610	74	50	66
Oesophagus	3248	1743	4991	71	65	68
Bladder	1521	318	1839	47	19	37

Kidney	788	72	860	40	6	27
Stomach	1385	266	1651	35	11	26
Pancreas	670	923	1593	20	26	23
Unspecified site						
Myeloid Leukaemia	264	131	395	19	11	15
Respiratory						
Chronic obstructive lung disease	13193	10685	23878	86	81	84
Pneumonia	3162	2900	6062	23	13	17
Circulatory						
Ischaemic heart disease	14182	6361	20543	22	12	17
Cerebrovascular disease	3064	3764	6828	12	9	10
Aortic aneurysm	3652	1939	5591	61	52	57
Myocardial degeneration	6670	2936	9606	22	12	15
Atherosclerosis	63	56	119	15	7	10
Digestive						
Ulcer of the stomach or duodenum	907	1008	1915	45	45	45
Total caused by smoking	71,296	43,219	114,597			
Preventable by smoking[10]:						
Parkinson's	1369	549	1918	55	28	43
Cancer of the endometrium		260	260		17	17
Total prevented by smoking						
Deaths from all causes due to smoking (causes less prevented)	69,927	42,410	112,337			

Deaths caused by smoking in the UK during 2002 were five times higher than the 22,833 deaths arising from:

- traffic accidents (3,439);
- poisoning and overdose (881);
- alcoholic liver disease (5,121);
- other accidental deaths (8,579);
- murder and manslaughter (513);
- suicide (4,066)
- HIV infection (234)

World-wide, almost 5 million die prematurely each year as a result of smoking. Based on current trends, this will rise to 10 million within 20 years (ASH *Online*)[11].

2.3 Asthma

According to ASH[12], there is sufficient evidence to suggest conclude that exposure to tobacco smoke increases asthma symptoms and attacks both for smokers and for non-smokers. Major governmental studies undertaken in the UK and the US have concluded that parental smoking is associated with increased prevalence of asthma in children, and among those with established asthma, parental smoking is

[10] Studies have shown that smoking appears to have a protective effect against the onset of some diseases such as endometrial cancer. However, the positive effect is so small in comparison with the overwhelming toll of death and disease caused by smoking that there is no direct public health benefit.

[11] ASH *Online* [http://www.ash.org.uk/, accessed May 2007].

[12] ASH *Online* [http://www.ash.org.uk/html/passive/html/asthma.html].

associated with more severe disease. Furthermore, there is substantial data confirming that infants whose mothers smoke during pregnancy have a higher risk of developing asthma and other respiratory illnesses including wheezing and coughing.

2.3.1 What is asthma?

Asthma causes irritation and inflammation of the airways within the lungs. Most people with asthma are allergic to certain things in the environment – these are known as allergic triggers. Common triggers are dust, pollen, air pollution, animal skin and cigarette smoke. However, asthma can also be non-allergic.

The National Asthma Campaign estimates that 3.4 million people in the UK currently have asthma, with 640,000 having severe or very severe asthma. Up to 100,000 people are admitted to hospital every year for asthma and almost half of these are children.

Asthma has increased significantly over the last 2-3 decades. The rise in asthma has been most noticeable in children. Possible reasons for the increase have been identified as:

- An increase in smoking by women during pregnancy
- Children's exposure to passive smoking
- Increased exposure to indoor allergens
- Outdoor air pollution e.g. smog
- Changes in diet, particularly a diet deficient in fruit and vegetables

Although there is evidence for all of the above, it is likely that no one single factor is the sole cause and that the increase in prevalence is due to a combination of these and other as yet unidentified factors.

2.3.2 Smoking and asthma

The link between tobacco smoke and asthma has been the subject of many epidemiological studies and research programmes, in the UK and overseas. Active smokers and non-smokers exposed to passive smoking, (also known as environmental tobacco smoking or ETS) have been found to be adversely affected.

Recent research from Finland has shown that passive smoking plays a role in the development of adult asthma. Researchers found that subjects exposed to tobacco smoke in the workplace were twice as likely to develop asthma as those who were not exposed.

Health effects for adult asthmatics include: asthma attacks; increased sensitivity and reduced lung function; irritation of the eyes, nose and throat.

Research carried out by the National Asthma Campaign showed that tobacco smoke is a trigger of asthma attacks in almost 80% of people with asthma. One study has shown how exposure to cigarette smoke for just one hour caused a 20% deterioration in the short-term lung function of adults with asthma. Up to a fifth of asthmatics continue to smoke, and those who do have worse symptoms and lung function than non-smoking asthmatics.

2.3.3 Children and asthma

Researchers have identified factors that might determine why a child is prone to wheezing and develops asthma, including:

- Maternal age
- Birthweight
- Prematurity
- Breastfeeding
- Family size
- Socio-economic status
- Atopy
- Lung function
- Diet

The bronchial tubes of children are smaller and their immune systems are less developed, making them more likely to develop respiratory illness when exposed to environmental tobacco smoke. Because they have smaller airways, children breathe faster than adults and consequently breathe in more harmful chemicals per pound of their weight than an adult would in the same amount of time.

In an analysis of data on 4,000 children aged 0-5 years, it was found that maternal smoking of more than 10 cigarettes a day was associated with higher rates of asthma, an increased likelihood of using asthma medication, and an earlier onset of asthma than was observed in children of non-smoking mothers.

A survey carried out by the children's TV programme, Blue Peter, in 1995 to which 10,000 children responded, showed that for 74% of children with asthma, smoky places made their asthma worse.

Research has also shown that when children have been hospitalised for acute asthma and return to a home where there is a smoker, their recovery is impaired. 82% of children that went home to non-smoking households had less than 1 symptomatic day per week compared with smokers with only 27% of the children who went home to households with smokers.

Exposure to passive smoking during childhood and *in utero* exposure (maternal smoking during pregnancy) are associated with adverse effects on lung growth and development.

Recent research undertaken at Nottingham City Hospital has shown that babies born to mothers who smoked were more likely to develop asthma than those who did not. The study used data from 15,000 children born during one week in 1970. Almost 40% of those children exposed to tobacco smoke, either in the womb or soon afterwards displayed asthma symptoms by the age of 16, compared to 29% who were not. This indicates that mothers who smoked during, or shortly after pregnancy, raised the chances of their children developing asthma by a third.

Research at Nottingham is continuing into which period of exposure to smoke (pre- or postnatal) is most harmful and exactly how smoke affects different causes of wheezing, such as infections or allergic asthma.

A further study assessed the effects of passive smoking on respiratory systems in a cohort of over 1,000 children born during 1980-84. Maternal prenatal smoking was associated with wheezing independently of family history of asthma, socio-economic factors and birth weight. This effect was attributed to changes that affect the early stages of lung development.

Research carried out at the Institute of Child Health in Bristol has shown that babies whose mothers continue to smoke during pregnancy have almost a 50% increased risk of being wheezy or having breathing problems.

A study of 11-16 year olds showed that asthma was more common among children who smoked but that the onset of the asthma symptoms preceded the start of smoking. It is unlikely that asthmatics are more inclined to take up smoking; a more likely explanation is that smoking increases the chances that asthma symptoms will persist.

2.3.4 Major studies linking passive smoking and asthma

1. UK Scientific Committee Report 1998
   - *"Smoking in the presence of infants and children is a cause of serious respiratory illness and asthma attacks".*
   - *"There is a need for public education about the risks of smoking in the home particularly in relation to respiratory diseases in children."*

2. The World Health Organization 1999
   - *"Both asthma and respiratory systems (wheeze, cough, phlegm) are increased among children whose parents smoke, on the basis of over 60 studies of school-aged children. The pooled relative risks for either parent smoking range from 1.2 to 1.4."*
   - *"ETS exposure causes the exacerbations of symptoms in children with asthma and in many countries this has led to the standard practice of recommending avoidance of tobacco smoke for children with asthma".*
   - *"There is convincing evidence that parental smoking is associated with increased prevalence of asthma and respiratory symptoms in school children. Among children with established asthma, parental smoking is associated with more severe disease."*

3. US Surgeon General 1986
   - *ETS can be causally associated with respiratory illnesses, including lung cancer, childhood asthma and lower respiratory tract infections.*

4. US Environmental Protection Agency 1992
   - "ETS exposure is causally associated with additional episodes and increased severity of symptoms in children with asthma. This reports estimates that 200,000 to 1,000,000 asthmatic children have their condition worsened by exposure to ETS."

5. California Environmental Protection Agency

   Respiratory Effects of ETS:

- *Acute lower respiratory tract infections in children e.g. bronchitis and pneumonia*
- *Asthma induction and exacerbation in children*
- *Chronic respiratory symptoms in children*
- *Eye and nasal irritation in adults*
- *Middle ear infection in children"*

6. US Environmental Protection Agency
   - *"There is sufficient evidence to conclude that complete avoidance of ETS would be associated with a lower likelihood of exacerbation of asthma in pre-school children with established asthma."*
   - *"There is sufficient evidence to conclude that complete avoidance of ETS would*
   - *reduce the probability of the development of wheezing with respiratory illness in younger children."*
   - *"There is limited evidence suggesting that complete avoidance of ETS would be associated with a lower likelihood of exacerbations of asthma in older children and adults."*
   - *"There is limited or suggestive evidence that complete avoidance of ETS would reduce the likelihood of the persistence of asthma or of new onset asthma in children and adults."*

2.4 Stress and smoking

The link between smoking and stress is well documented and smokers often deal with stress by lighting a cigarette. Nicotine causes the brain to release chemicals, called neurotransmitters. Some of these chemicals, such as beta-endorphin and norepinephrine, can cause a person to feel better, but only for a short time. They can improve your mood for a while. So, smoking can serve as a quick "pick-me-up." Indeed, nicotine is a stimulant, which is why a smoker's pulse gets faster after a cigarette.

Aside from this chemical reason that smoking might seem to help someone who is under stress, there are also other reasons. Smokers often use the act of lighting and smoking a cigarette as a "time out" from thinking about or dealing with stress. Like any activity, smoking can distract a person from his or her troubles. Also, because smoking is often a social activity, some people find that lighting a cigarette brings to mind feelings of group support. This can comfort people in times of stress. Lastly, an addicted smoker will feel better after smoking because it relieves nicotine withdrawal symptoms (smokefree.gov, *online*).

However, the relief only lasts a short time. Soon the stress will return and the smoker will need another cigarette. In summary:

- Smoking does not solve the problem; it only hides it. The cause of the problem remains.
- Smoking actually causes more stress than it relieves. Parrott[13] reviewed studies on the smoking/stress relationship and found that the positive mood

[13] Article: "Does Cigarette Smoking *Cause* Stress?" Andy C. Parrott, Ph.D., University of East London, *American Psychologist,* Vol. 54, No. 10.

changes experienced during smoking may only reflect the reversal of unpleasant abstinence effects. "Regular smokers, therefore, experience periods of heightened stress between cigarettes, and smoking briefly restores their stress levels to normal," said Professor Parrott.

"However, soon they need another cigarette to forestall abstinence symptoms from developing again. The repeated occurrence of negative moods between cigarettes means that smokers tend to experience slightly above-average levels of daily stress. Thus, nicotine dependency seems to be a direct cause of stress."

2.5 Mental health

ASH[14] tells us that many epidemiological studies have reported an association between clinical depression and smoking. Some have concluded that the effects of long-term nicotine exposure on the brain may have a causal influence on major depression while others suggest that shared environmental or genetic factors may predispose to both smoking and major depression.

A study by Kendler *et al* suggested that the relationship between smoking and major depression results solely from genes that predispose to both conditions. Other potential shared aetiologies are factors in the social environment, personality (for example, low self-esteem), and coping styles. Nicotine may act as an anti-depressant in some smokers and could therefore be viewed as a form of self-medication.

When individuals with a history of depression stop smoking, depressive symptoms and, in some cases, serious major depression may ensue. This accounts for the lower smoking cessation rates in depressed individuals as compared with smokers who do not have depressive symptoms. A study by Kinnunen et al showed that only 37% of the depressed smokers in their sample population were able to abstain for one week, whereas 56% of non-depressed were able to do so.

The evidence so far is inconclusive and there is dispute among scientists as to whether smoking is the cause, or effect of mental illness. However, some researchers believe that smoking itself could act as a trigger for mental illness. In a review of the evidence to assess the links between tobacco smoking and mental disorder, two public health researchers concluded that nicotine dependence is indeed a mental disorder, from which most smokers suffer. They found that nicotine dependence was strongly associated with a variety of other mental disorders. Mental disorder was linked with an increased propensity to smoke and a reduced likelihood of cessation.

2.5.1 Schizophrenia

Patients with schizophrenia have an extremely high prevalence of smoking; a US study in 1986 found about 88% of patients were smokers. The reason for this is unknown, but it is likely that smoking behaviour in schizophrenia is a complex process. The increase in dopamine release induced by smoking may be helpful in

[14] http://www.ash.org.uk/html/factsheets/html/fact15.html

alleviating some schizophrenic symptoms. Therefore, schizophrenics may smoke in an attempt to self medicate.

2.5.2 Alzheimer's Disease and Dementia

Studies conducted in the early 1990s suggested that smoking had a protective effect against AD. Although research on this subject has failed to be conclusive, it was thought that nicotine could delay the onset of familial AD. Acetylcholine binds to receptors, known as nicotinic receptors, to exert its effect. A loss of neurons leads to a loss of these receptors and this is associated with the aetiology of AD. It was hypothesised that nicotine from cigarettes may compensate for the loss of nicotinic receptors in AD and therefore postpone the onset of the disease.

Scientists at the Scripps Research Institute, California, have discovered that nornicotine, a by-product of nicotine, appears to prevent the abnormal build-up of amyloid protein plaques associated with Alzheimer's disease. However, the research did not demonstrate that smoking had any protective effect for AD. Other research has shown that smoking increases the risk of AD and vascular dementia by increasing the amount of free radicals in the body, which impair brain and body cell functions and undermine immunity. **i[14]**

Recently, scientists have begun to challenge the protective role of smoking hypothesis. They point out that earlier studies assumed that the genetic susceptibilities of a population of older surviving smokers was the same as that of the age matched non-smokers. However, it has been suggested that older surviving smokers must have relatively more effective DNA repair mechanisms than comparable non-smokers. Therefore, if AD is related to the accumulation of ageing-associated defects in DNA and DNA repair, older surviving smokers may be less susceptible to AD. This could explain the apparent inverse relationship found by many studies in the past.

A study involving 17,600 people aged 65 and over, screened the participants for dementia. The survey, conducted in Britain, Denmark, France and the Netherlands looked at the effect of smoking on cognition in non-demented elderly. It concluded that smoking may indeed accelerate cognitive decline in non-demented elderly.

Even if smoking is "protective" against AD, smoking could never be advocated for this purpose. This is because the known health risks of smoking far outweigh any possible reduction in risk of getting AD in later life.

2.5.3 Parkinson's Disease

Parkinson's Disease is characterised by the symptoms of tremor, rigidity, bradykinesia (slowness of movement) and a lack of facial expression. Many studies have shown that smoking is protective against PD. PD occurs because there is a loss of dopaminergic neurons in the brain. These are neurons that release dopamine as their neurotransmitter and they are important in ensuring accurate movements of muscles as commanded by certain areas of the brain. It is thought that nicotine may have its effect by restoring dopamine to normal levels in the brain. Again, the researchers emphasise that the possible benefits of smoking on PD risk would be small (the incidence rate of PD is only about 1-2%), and the health hazards associated with smoking would far outweigh any conceivable protection against PD.

However, the findings should be viewed as potentially advancing the current understanding of the underlying pathology of PD.

Choosing Health summarises the link between smoking and mental health. The report stresses that improving mental health is an overarching priority “because mental well-being is crucial to good physical health and making healthy choices”.

3.0 The policy backdrop

3.1 National DH smoking cessation program

There are 6 strands to the program:

1. A healthier England from 1st July 2007

Through smokefree legislation, virtually all enclosed public places and workplaces in England will be smokefree, including all pubs, clubs, membership clubs, cafes and restaurants from 1 July 2007.

2. Reducing exposure to secondhand smoke

Secondhand smoke (also known as 'environmental tobacco smoke' (ETS) or 'passive smoking') is a mixture of side stream smoke from the burning tip of a cigarette, and mainstream smoke exhaled by a smoker. Secondhand smoke kills, and scientific evidence shows that there is no safe level of exposure.

3. Tobacco media/education campaigns

A key strand of the Government's tobacco control programme is the provision of an ongoing media/education campaign. These campaigns are now the number one reason smokers in the UK decide to try and quit.

4. Reducing availability of tobacco products and regulating supply

Price increases have been a highly successful way of helping people become non-smokers: UK budget changes to tobacco duty have saved lives and prevented much serious illness

5 NHS Stop Smoking Services & Nicotine Replacement Therapy

The Government has set up a comprehensive NHS Stop Smoking Service. Services are now available across the NHS in England, providing counselling and support to smokers wanting to quit, complementing the use of stop smoking aids Nicotine Replacement Therapy (NRT) and bupropion (Zyban).

6 Reducing Tobacco Advertising and Promotion

Strong evidence exists linking the prohibition of tobacco advertising with a decrease in smoking levels. That is why the UK has a comprehensive ban - just like many other countries in Europe and beyond. It is estimated that in the long term, the UK advertising ban will lead to a 2.5% decrease in smoking levels.

3.2 National cessation services

The Government has set up a comprehensive NHS Stop Smoking Service. Services are now available across the NHS in England, providing counselling and support to smokers wanting to quit, complementing the use of stop smoking aids Nicotine Replacement Therapy (NRT) and bupropion (Zyban).

Services are provided in group sessions or one to one, depending on the local circumstances and client's preferences. Most stop smoking advisers are nurses or pharmacists, and all have received training for their role. £138m was made available to the Services over the three years 2003 -2006 (£41m/£46m/£51m).
To build on the continued success of the services, a further £112 million for the two years 2006/07 - 2007/08 has been allocated to Primary Care Trusts (PCTs), including an additional £10 million heavily weighted towards spearhead PCTs.

The Government has made stop smoking aids available on NHS prescription (bupropion (Zyban) June 2000 and NRT April 2001). The National Institute for Clinical Excellence (NICE) has issued guidance on the use of NRT and bupropion (Zyban) and the role of counselling and support. In 2004 around 2 million prescriptions for NRT were dispensed worth a total value of around £44 million. NRT or Zyban doubles the chances of a smoker successfully quitting and use has increased substantially year on year.

The Department of Health funded an evaluation of the NHS Stop Smoking Services programme, which was carried out by a team led by Glasgow University. The evaluation included an overview of the development and staffing of services, an analysis of characteristics associated with the more successful services, conclusions on the targeting of disadvantaged smokers, a summary of cost effectiveness, and a pilot study of long term effectiveness which looks at the extent to which smokers who successfully quit smoking after four weeks are still not smoking after a year.
The main findings were that:

- The services can contribute to a (modest) reduction in health inequalities
- Long term quit rates for the services show about 15 per cent of people remain quit at 52 weeks, which is comparable with earlier clinical trials
- The services are cost effective in helping smokers quit

This means that a smoker who tries to quit with the NHS Stop Smoking Service and NRT/Zyban is up to four times as likely to succeed than by willpower alone.

3.3 Regional tobacco policy

Regional Tobacco Policy Managers are responsible for coordinating activity on a regional level. Each of the nine Government Regions has a Regional Tobacco Policy Manager. Their role is to provide strong regional leadership on tobacco control to deliver the goals of the national tobacco control programme through region wide action involving key partners and to facilitate regional change.

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Andrew's role is largely advisory. It would be useful to keep him in the loop with developments in Lewisham so he can cascade any findings across the London network.

Andrew drew our attention to the forthcoming NICE report into reaching hard to reach groups with smoking cessation.

3.4 Health Action Zones

The government launched the health action zone (HAZ) initiative in 1997. Twenty-six HAZs were set up as seven-year pilot projects 'to explore mechanisms for breaking through current organisational boundaries to tackle inequalities and deliver better services'. HAZs were meant not only to improve health outcomes and reduce health inequalities, but also to act as trailblazers for new ways of local working.

The HAZs had focused mainly on changing ways of working to enable local partnerships to tackle health inequalities. Their achievements were that they had:

- Pushed health inequalities up the local agenda, including raising the profile of 'hidden' issues and groups
- Broadened understanding of the determinants of health and gained ownership from a range of partners
- Helped develop partnership structures and collaborative working
- Helped develop more systematic planning processes
- Improved some mainstream services, especially in disadvantaged areas.

The HAZs felt that their direct impact on health inequalities was minimal – because of the short timeframe of the HAZ initiative and limited resources – although specific projects had changed individuals' lives. HAZs have now been incorporated into the development of primary care trusts.

Changes in national policy, including the NHS reforms and the emergence of local strategic partnerships, changes in HAZ priorities, and uncertainty about their future reduced the HAZs' ability to influence local policies.

The Health Action Zone programme for Lewisham ended on 1 April 2006.

3.5 Lewisham cessation policy and targets

Stop smoking LPSA and LAA target breakdown

2005/8 4 week quitters 5867 (60 stretch)
2005/8 52 week quitters 1760 (18 stretch)

2005/6 4 week quitters 2114 (no stretch)
52 week quitters 634
2006/7 4 week quitters 1604 (30 stretch)
52 week quitters 481

2007/8 4 week quitters 2149 (30 stretch)
52 week quitter 645

The PCT has exceeded its stop smoking target of 1574 for 2006/7. This is the first time they have ever got beyond a red rating. This means the PCT will get a green rating from NHS London for this level of performance.

Target and Performance
LPSA targets:
5867 4 week quitters.
Total achieved to date - 2800 (1224 -2005/6, 1576 - 2006/7)
To be achieved **2007/8 - 3067**

[15] There is an issue to be resolved with GOL regarding the time period in which quits are collected, due to the time lag between setting a quit date and the outcome 4 weeks or 52 weeks later. Some data will therefore be included on 4 week quitters from Q4 for 2004/5.

Lewisham PCT's plan to increase cessation rates

- Target those who have already shown an interest in stopping who have not yet been successful.
- Contact smokers through GP practices to encourage them to quit including the following:
    - Lewisham Community Development Partnership working with practices to contact smokers and provide stop smoking groups
    - Use of telemarketing with practices in NDC area.
    - Encourage practices to contact smokers.
    - Explore use of text messaging to contact smokers in practices.

- Ensure that there is a diverse range of level 2 provision and supporting current advisers
- Providing on going support to current providers, including 29 pharmacies, 29 GPs, 4 voluntary sector providers and sessional advisers, through:
    - Newsletter
    - Update sessions
    - Visits and telephone support

- Changing the provision of Level 3. The contract with the Specialist Stop Smoking Clinic will be terminated in December 2007 and other level 3 services are being developed.

- Training and supporting new advisers:
  Level 1
  4 courses planned up to December for all comers and specialist sessions provided on request. One planned with youth service but previously cancelled due to lack of uptake.

  Level 2
  4 courses planned upto December and targeted training also provided included GP practices and Boots.

  QUIT training on 'Working with young smokers' planned and funded by Healthy Schools Partnership. Youth service and YOT withdrawn, although previously committed.

- Promote the use of the service as a means of increasing success.
- Use the smoking ban to advertise the service and promote it as a time to quit.

- Joint communications plan with Stop Smoking Service tel. no. always advertised with smokefree no. Examples include: launch of Tobacco Control Alliance and smokefree on 23rd June; websites; noticeboards; countdown
- Organise a range of outreach events
- Workplace advice provided on request - group sessions

- Promote the new medication Champix if this is advised in this summer's NICE guidance.

- Social marketing project in Evelyn Ward. The National Social Marketing Centre (NSMC) is supporting Lewisham PCT in adopting a social marketing approach to the Stop Smoking Programme. This will be one of the first demonstration projects in the UK to show the value of systematically applying marketing concepts and techniques to address a behavioural goal, which will improve health and reduce inequalities.

Budget 2007/8
PCT - £309k for Stop Smoking Service (no longer includes the cost of medication)
LAA - £50k community development - commissioned North Downham Training Project and Voluntary Action Lewisham
LPSA/LAA £12k plus £30k -

- Improve data collection from GP practices
- Offer a proactive approach to smokers on patient lists
- Target smokers to invite them to use group or one to one support.
- Improve the quality of support provided to smokers

3.6 Lewisham Tobacco Control Alliance

This alliance aims to work collectively towards the shared goal of reducing health inequalities and smoking, and to create a healthier environment for every citizen who lives, works, studies in and visits the borough.

The alliance aims to enable the people of the borough to make positive choices about their own health and wellbeing, and that of those around them, by providing community leadership in prevention, risk reduction, enforcement and support to reduce the prevalence of smoking and its related consequences.

The alliance aims to contribute to the de-normalisation of tobacco through:

- Preventing the uptake of smoking
- Protecting the public from tobacco smoke
- Promoting smoking cessation
- Challenging tobacco providers.

The alliance will drive forward an action plan with timescales and success measures. The plan will be reviewed annually.

The alliance will:

- Contribute to the coordination and implementation of the tobacco control strategy
- Plan, develop and implement agreed evidence-based initiatives in tobacco control, in line with the local and national strategies
- Share and disseminate good practice in tobacco control.

The way the alliance will deliver these functions will be by:

- Strategic decision making
- Influencing partners at the top level and embedding the agenda

- Developing a community –wide response to tobacco control
- Integrated outcomes
- Performance management
- Evaluation
- Commissioning.

The London Borough of Lewisham will chair the alliance, but the responsibility for its success will rest with all partners.

Membership to be drawn from:

LBL
Planning
Children and young People's Directorate
Licensing
Health and Safety
HR
Staff side
Town centre team
Regeneration
Leisure
Communications
Cabinet

Education
School head teachers
Governors

Health
Public health
Health First
HR
Staff side
Children's services
PEC
UHL
SLAM
Primary Care
Independent Contractors

Other key partners
Police
Fire
Cessation service providers
Community Drug Education Service
Lewisham College
Chamber of Commerce
Voluntary Action Lewisham
Faith groups
LVA
Pensioners' forum

4.0 The workplace smoking ban

ASH tells us that evidence suggests that exposure to secondhand smoke in the workplace causes around 617 premature deaths in the UK each year. This can be compared with the total number of deaths in the UK from all industrial accidents, reported by the Health and Safety Executive to be 235 in 2003/4. Particularly at risk are bar staff, casino workers and other employees in workplaces where smoking is routine.

The Public Health White Paper, 'Choosing health, making healthier choices easier', sets out the government's strategy for achieving better national health, including reducing the numbers of people who smoke. Given the danger of secondhand smoke, a key recommendation is to achieve smokefree public places:

- by the end of 2006, all government departments and the NHS were made smokefree
- by the end of 2007, all enclosed public places and workplaces (other than those specifically exempted) will be smokefree.

The implications of these bans are crucial to any future social marketing intervention that Lewisham implements and a full understanding of the predicted public response is necessary.

4.1 Impact on smoking rates and cessation

It is known that ending smoking in workplaces is a simple and cost-effective way to encourage smokers to quit. Wanless reported to the UK Government that "A number of other countries have now implemented a workplace smoking ban via legislation. Some of this experience has been shown to be successful in reducing the prevalence of smoking".

He continues: "Some studies estimate that a workplace smoking ban in England might reduce smoking prevalence by around 4 percentage points – equivalent to a reduction from a 27% prevalence rate to 23% if a comprehensive workplace ban were introduced in this country." According to the Regulatory Impact Assessment of the Health Bill, the Government predicts a fall in smoking prevalence of 1.7%, resulting in almost 700,000 fewer smokers.

Fichtenberg and Glantz (2002)[16] found in their systematic review that totally smoke-free workplaces are associated with reductions in prevalence of smoking of 3.8% and 3.1 fewer cigarettes smoked per day per continuing smoker. Combination of the effects of reduced prevalence and lower consumption per continuing smoker yields a mean reduction of 1.3 cigarettes per day per employee, which corresponds to a relative reduction of 29%.

If all workplaces became smoke-free, consumption per capita in the entire population would drop by 4.5% in the United States and 7.6% in the United Kingdom.

4.2 Current law and new legislation

16 Fichtenberg, CM and Glantz, SA (27th July 2002). Effect of smoke-free workplaces on smoking behaviour: systematic review. BMJ 2002;325:188

The bill to ban smoking in virtually all workplaces in England was approved by Parliament in July 2006 and is due to come into effect in July 2007. Despite a public consultation which revealed overwhelming support for a comprehensive smoking ban, the Government initially retained the proposed exemptions for pubs and clubs when it published the Health Bill in late 2005. However on 14 February 2006, MPs voted with a large majority to remove the exemptions for pubs and clubs. The bill received majority support in the House of Lords and became law in July 2006.

Separate measures apply to Wales and Northern Ireland which are also due to come into force in 2007. Scotland has already enacted legislation which took effect from 26 March 2006.

4.3 Public support for new legislation

As awareness of the health risks of passive smoking has grown, demand for smoke-free public places has dramatically increased. The 2003 Office for National Statistics survey found that for the 55% of non-smokers who mind if people smoke near them, tobacco smoke causes a variety of problems: 21% said it affected their breathing; 17% said it irritated their eyes, and 17% said it made them cough.

There is overwhelming public support for new legislation to end smoking in the workplace. In May 2004, a MORI poll of over 4,000 respondents, commissioned by ASH, showed that four out of five (80%) of those polled support a law to ensure that all enclosed workplaces must be smokefree.

Research participants were asked, "Ireland, Canada, Norway and New Zealand have each passed laws to ensure all enclosed workplaces are smoke free. How strongly, if at all, would you support or oppose a proposal to bring in a similar law in this country?"

Strongly support a smoke free law	54%
Tend to support	25%
Neither support nor oppose	8%
Tend to oppose	7%
Strongly oppose a smoke free law	4%

4.4 Uptake of smoking

Unrestricted smoking in public places may influence youth smoking in four ways[17]:

- Adults who can freely smoke anywhere increase the amount of negative role modelling to youth.
- In such environments, youth are presented with more opportunities to smoke. It is well known that smoke-free policies limit opportunities for smokers to smoke cigarettes. Particularly at work, smokers who are subject to smoke-free policies never completely compensate for cigarettes foregone if they had been able to smoke freely. Studies indicate that this applies equally among adolescent workers, limiting the likelihood that low rate opportunistic smoking might consolidate into regular adult smoking.
- As a consequence of the second point, unrestricted smoking permits opportunities for social or non-commercial exchange of cigarettes between youth. Other

[17] Wakefield and Forster (2005)

adolescents are the most important source of cigarettes for many young smokers, especially the youngest. Formal restrictions on where they can smoke as well as social disapproval of smoking in public reduce their opportunities for smoking in groups.

- Finally, if smoking is freely permitted, smoking is implicitly communicated to be an acceptable behaviour for members of a society. The more visible smoking is, the more it is perceived by adolescents as socially acceptable and normal.

Thus, clean indoor air laws that include social venues such as restaurants may have indirect influences on youth smoking through substantially influencing the pattern of adult smoking in a community. More generally, measures of tobacco related social norms such as perceived social acceptability of smoking and perceived smoking prevalence have been demonstrated to be significant predictors of adolescent smoking and uptake.

Cross sectional studies also point to beneficial effects on youth smoking of smoking bans in the home and strongly enforced smoke-free policies at school. A recent study found that adolescents with a household smoking ban were more likely to perceive lower adult smoking prevalence, and perceive there to be greater disapproval of adult and youth smoking.

4.5 Evidence from Scotland

The Scottish ban took place on 26th March 2006. In January 2007, the BBC[18] reported that the ban has increased the number of quit attempts in the country.

First Minister Jack McConnell said the ban had been a major success and would create tangible long-term benefits. He said: “Even after one year, Scotland is a healthier place and people, both in work and at leisure, are able to avoid the atmosphere which in the past caused them health problems."

The anniversary of the Scottish smoking ban comes as a new report revealed how many people used NHS smoking cessation services in 2006. ISD Scotland found that

- there were 46,466 quit attempts made during the year
- January to April were the busiest months for services (in the lead up to the ban)
- an estimated 4.3% of smokers in Scotland tried to stop with an NHS smoking cessation service
- a follow-up one month later revealed that 34% had quit, 34% were still smoking and results for 32% were unknown.
- after a three month follow-up, the quit rate was 18%.

These initial findings suggest that the ban has encouraged people to give up smoking, with the number of people contacting cessation support services increasing in the run-up to the ban's introduction.

4.6 Evidence from the Republic of Ireland

The indoor workplace smoking ban was implemented in Ireland in March 2004. Allwright (2004)[19] tells us that in the run-up to the ban there were large increases in

18 http://news.bbc.co.uk/1/hi/scotland/6491471.stm

the number of calls to quitlines. Preliminary figures suggest increased sales of nicotine replacement therapy products, and reports from GPs of increased requests for help to stop smoking.

Also there was a predicted 16% decline in cigarette sales.[20] This is the highest short-term reduction ever recorded in the Republic of Ireland — or anywhere else. The 13% decline in cigarette consumption in New York after its ban was attributed to a steep increase in tobacco taxes and a citywide antismoking campaign as well as the ban itself. As the price increase in the Republic of Ireland was unexceptional, the Irish decline may be largely attributable to the smoking ban.

Two key factors in Ireland led to its success in reducing smoking rates

1. **Cessation infrastructure**

A platform of smoking cessation structures had been evolving in Ireland leading up to the ban. Nicotine replacement therapy had been available since 2001 free of charge to medical card holders (the poorest third of the Irish population), who also have the highest smoking rates. Quitlines and health board cessation clinics had been developed across the country and cessation training offered to GPs, practice nurses, and pharmacists. Links between health boards and environmental health officers and restaurants, pubs and other workplaces had been developed for various health and safety initiatives, which could then be used to support and monitor the new smoking legislation.

2. **Awareness of the ban**

Awareness and rationale for the ban were high in the lead up to March 2004.
Allwright explains that:
"The year of often heated debate — in newspapers, on television, on national and local radio, through expert discussions and phone-ins — meant that no one in the Republic of Ireland remained ignorant of the impending ban, that everyone had an opinion, and that popular support strengthened over the course of the debate as people began to perceive the self-serving nature of the hospitality industry's economic arguments."

Potential negative aspects of the ban are described as:

- Detrimental economic effects on the hospitality industry have been recorded but the negative outcomes of passive smoking (including economic effects) far outweigh the negative consequences to the hospitality trade
- The possibility of increased smoking in the home, and a subsequent increase in exposure of children to passive smoke. However, an Australian study showed that people who worked in places where smoking was totally banned were more likely to ask visitors not to smoke in their homes than those who worked where smoking was allowed.

19 Allwright, S, (Nov 2004). Republic of Ireland's indoor workplace smoking ban. British Journal of General Practitioners. 54(508): 811–812.

20 Based on figures from the Revenue Commissioners for the first 6 months of 2004

5.0 Introduction to social marketing and evidence for its potential

Hastings (January 2007, unpublished)[21] explains that developments in public health show that engaging with social marketing to change voluntary behaviour "is not only desirable, but a matter of life and death. We are now entering an era when chronic, lifestyle related illnesses are a greater risk to life and limb than the more familiar communicable killers of yesteryear… In this climate, insights into how behaviour can be influenced are at a premium; our very lives depend on them".

Social marketing, then, is an approach to behaviour change that uses commercial marketing techniques to change behaviours for the social good. Commercial marketers have had decades of success in changing our behaviours. We wear their brands, loyally buy their products and tell our friends to do the same. Hastings strongly suggests that if social marketers use the same techniques with the same support of evidence and behavioural insight as commercial leaders such as Tesco, Diageo and Mars, we will see the same behaviour change successes:

> Research reviews have established that alcohol, tobacco and food marketing all have a significant impact on our drinking (Hastings *et al*, 2005), smoking (Lovato *et al.*, 2003) and eating behaviour (Hastings *et al*, 2003, McGinnis *et al.*, 2006. Social marketing can emulate this success.
> (Hastings, January 2007, unpublished)

Hastings goes on to quote systematic reviews undertaken by the Institute of Social Marketing (for the National Social Marketing Centre) which have shown that social marketing ideas and techniques can successfully modify patterns of exercise, drinking, smoking and drug use. He states that "It comes as no surprise, then, that a recent UK Government white paper talks of the *"power of social marketing"* and of *"marketing tools applied to social good"* being *"used to build public awareness and change behaviour"* (Department of Health, 2004: p21)[22].

However, there is a strong caveat to this support of social marketing as a potentially forceful weapon in the battle against health and social ills: Marketing requires rigorous insight into the target audience. According to the National Social Marketing Centre, one of the benchmark criteria for a social marketing intervention is consumer insight. This criterion is taken from Kotler and Zaltman's original 1971 definition, which explains that social marketing utilizes

> …concepts of market segmentation, *consumer research*, product concept development and testing, directed communication, facilitation, incentives, and exchange theory to maximise the target adopter's response.
> (Andreasen, 2002)

Experience shows that social marketing interventions targeting working class groups have traditionally failed to achieve their behavioural goals, possibly because the psychological and socio-cultural barriers specific to C2DE adults may not have not been fully researched and applied to these interventions.

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[21] Hastings, G (January 2007) The new diaspora has already begun

22 Department of Health (2004), Choosing Health: making healthier choices easier. Public Health White Paper, Series No. CM 6374, The Stationery Office, London.

For example, health promoters have been refining the anti-smoking message for over a century (Lambert *et al*, 2002), yet there has been little change among lower income groups:

> Since 1973, rates of cessation have more than doubled in most advantaged groups (from 25 – 50%) but in poorest groups, increased only from… 10-13% in 1996. These figures suggest that previous health promotion measures… have not been effective among the lower income groups.
> (Richardson, 2002)

Also, despite constant '5-a-day' campaigns, food intake statistics show that consumption of fruit and vegetables is far lower in the lower socio-economic groups than higher groups (Heart Stats, 2006). Similarly, Hillsdon *et al* (2001) found that after the Department of Health's ACTIVE for LIFE exercise social marketing campaign, awareness of the message was high, but "exposure to the campaign seemed to make little difference to the proportion of active subjects." Again, Lambert *et* al (2002) provide evidence that the 'five a day' healthy eating campaign has failed to engage with deprived groups.

Only well-informed, insight-driven social marketing can instigate significant changes to behaviour.

5.1 Strategic potential of social marketing

5.1.1 Upstream social marketing

Social marketing can have a range of behavioural goals (as long as the goal is for the social good) and use a range of techniques targeting a range of clients. Interventions can be split into the following (a model which will be used when assessing the interventions in a later chapter):

	Control	**Design**	**Support**	**Educate**
Intervention options	Legislation Regulation Enforcement Requirement Standard setting	Design and engineering for the environmental and physical context Increasing availability Improving distribution	Providing support Servicing support Responding to what people need, want and/or value	Informing Advising Building awareness Persuading Aspiring
Example	No smoking allowed at work	Smokefree pubs	Smoking cessation services	Information about the dangers of smoking

It could be said that because the cessation services and information campaigns target individuals who already smoke they are 'downstream' interventions whereas an social marketing intervention may have been implemented to contribute to the pressure on the government to implement the smoking bans, and this is considered 'upstream'.

Social marketers must weigh up the pros and cons of spending their budget on upstream or downstream interventions. Hastings (2007, unpublished) advocates the

consideration of an upstream focus for social marketing interventions and poses the question:

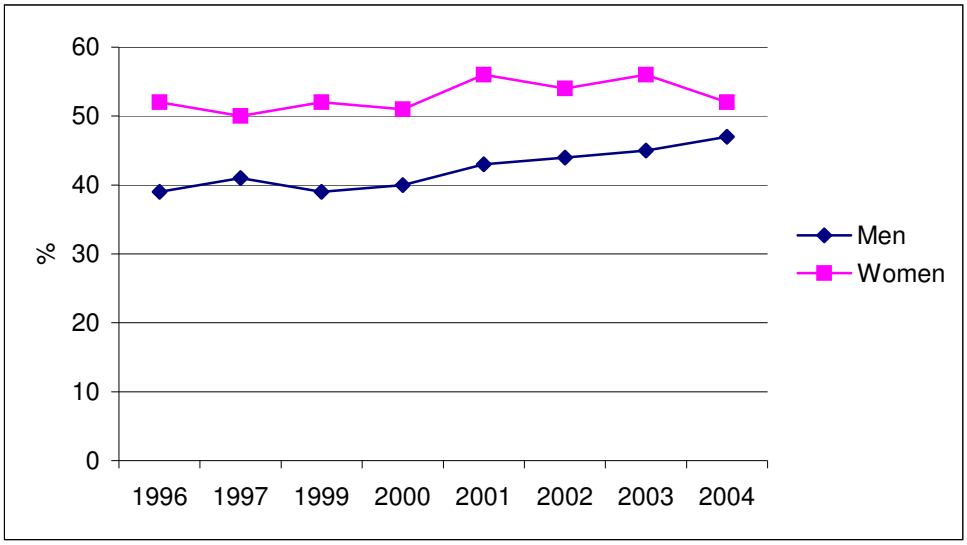
> "Should we focus our efforts on influencing individuals to give up smoking, drive more safely or eat less fat (what Wallack would term 'down-stream' behaviour change)? Or should we also be trying to influence the policy makers, politicians, regulators or educators to restrict access to tobacco, make roads slower and cars safer, or improve the nutritional value of food products ('up-stream' behaviour change)?"

The effects of either an up- or down-stream focus, in terms of health, perceived benefit and economic improvement, may be considerable and should be carefully evaluated.

5.1.2 Prevention or reaction

It is worth considering the strategic position of social marketing with regards to the issue of smoking prevention. Looking at the percentage of adults who have never or only occasionally ever smoked, there has been gradual increase amongst both men and women since 2000. The current rate is 47% for men and 52% for women.

Cigarette smoking status (percentage) among adults, 1996-2004: Never or only occasionally ever smoked



Source: ONS Omnibus Survey 2004: Adapted from Lader & Goddard 2005:[23]

This suggests that prevention may be a viable behavioural goal in smoking social marketing interventions. In her 2004 Guardian[24] article 'Prevention not cure', Coote envisioned a future with health centres for the well, aimed at preventing illness, and where treatment is a last resort and critically where individuals go not as a 'patients' but expecting to play an active role in maintaining their own health.

Coote described her vision as follows:

"Think… of a local health centre where people go when they are well for a thorough health check at regular intervals - say every three years. It provides information, advice and monitoring. When people get ill, it provides access to healthcare, but as a secondary function. It's a more equal relationship. The clinical staff and others who

23 The New Consumer Agenda – a public debate. National Consumer Council.

24 Thursday March 18, 2004 http://society.guardian.co.uk/publichealth/comment/0,11098,1171630,00.html

work at the centre act as champions for health. Part of their job is to identify local health problems and needs. They are well connected with other local organisations, public and voluntary, and work with them to promote healthy conditions at neighbourhood level".

Coote explains that in her mind the real challenge is to shift resources 'upstream' into preventive services that focus on enabling individuals to choose healthy lifestyles. It would be valuable to consider the role that social marketing might have to play in changing the relationship that people, particularly in deprived communities, have with their own health rather than always focusing on attempting to change negative health behaviours.

Therefore, despite the focus of the proposed Evelyn social marketing intervention, prevention interventions and interventions focused on changing attitudes to health will be included in the Intervention Review chapter for consideration by stakeholders and to provoke further discussion.

6.0 Clients

6.1 Lewisham

6.1.1 Population

The 2001 census stated that Lewisham had the following demographics:

	2001
All	248,922
Males	119,520
Females	129,480
Aged 10-17	10,467
Aged 16-17	5,934
Aged 18-44	118,209
Aged 60 and over	36,170

Sixty-six per cent of the population is from the White ethnic group, 4% from the Asian ethnic group and 24%from the Black ethnic group, compared to 71%,12% and 11% respectively in London as a whole[25]. As of 2006, Lewisham has the following ethnic profile:

Ethnic Group	**Lewisham**
White	65.9
Mixed	4.2
Asian or Asian British	3.8
- Indian	1.4
- Pakistani	0.4
- Bangladeshi	05
- Other Asian	1.5
Black of Black British	23.4
- Caribbean	12.3
- African	9.1
- Other black	2.1
Chinese or other ethnic group	2.7

Source: Equity profile review (Jane Miller)

6.1.2 Socio-economic indicators

Lewisham is in the worst 20% boroughs for deprivation and ranks 57th out of 354 districts in England for the highest Index of Multiple Deprivation.[26]

The 2006 Lewisham Health Profile tells us that

- Seven of Lewisham's 18 wards are among the most deprived in England.
- Lewisham has more poor quality local authority housing and more violent crime than England as a whole
- Teenage pregnancy is high and GCSE achievement is low
- More of Lewisham's older people are supported to live at home than the average for London.

[25] 2006 Lewisham Health Profile

[26] Queens Road Partnership Health Profile, June 2006.

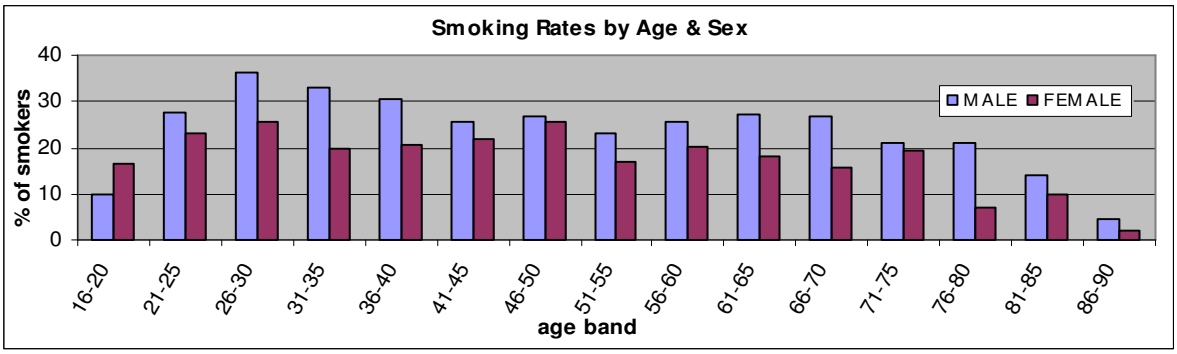
6.1.3 Health

- Life expectancy is lower in Lewisham than it is average for England.
- Deaths from smoking, heart disease and stroke, and cancers are more common.
- Road injuries and deaths are high, even for London which has higher rates than England.
- People in Lewisham are more likely to be feeling in poor health.
- Few people are recorded with diabetes.
- There is a low level of children 's tooth decay compared to the national average.
- The number of people registered with the GP for severe mental health problems is high. This may be due to higher than average need or to higher numbers using services.
- None of Lewisham 's wards has significantly better life expectancy than England. Wards with the lowest life expectancy lie to the north and west of the borough.

6.1.4 Smoking in Lewisham

- A smoking prevalence of approximately 33% is estimated for Lewisham[27].
- 31% of the households surveyed for the 2004 Lewisham Quality of Life Survey had a member who smoked (Miller, 2006)[28].
- In Lewisham out of 1302 smokers accessing the Stop Smoking Service, 42% (n=547) have successfully quit.[29]
- A normal distribution of smokers by age seems to be apparent in Lewisham:

Snapshot of Smoking Rates by Age and Sex on 9.2.06



SOURCE: QRP EMIS LV, 9.2.2006

The Quality and Outcomes Framework provides data on patients registered with Lewisham GPs diagnosed with chronic disease. The percentage of those smoking in each group is outlined below.[30]

27 Liz Twigg, Graham Moon and Sarah Walker The smoking epidemic in England,

Institute for the Geography of Health, University of Portsmouth, Health Development Agency (2004). Cited by Miller, J (2006).

28 Data from the Quality of Life survey should be interpreted with caution due to a response rate of only 5.8%

29 Queens Road Partnership Health Profile, June 2006.

30 It is important to note that these groups are not mutually exclusive, as some people will have more than one disease.

- 28% of the 2,803 patients with a history of transient ischaemic attack or stroke who have a record of smoking status in the last 15 months (92%) were smokers (500).

- 18% of the 5,863 patients with coronary heart disease who have a record of smoking status in the past 15 months were smokers (1,049).

- 15% of the 9,989 patients with diabetes who have a record of smoking status in the last 15 months (96%) were smokers (1,524).

- 38% of the 2,765 patients with Chronic Obstructive Pulmonary Disease who have a record of smoking status in the last 15 months (95%) were smokers (1,042).

- 26% of the 11,199 patients aged 20 and over with asthma who have a record of smoking status in the past 15 months (91%) were smokers (2,876).

- 16% of the 28,347 patients with hypertension who have a record of smoking status in the past 15 months (96%) were smokers (4,409).

Lewisham summary
- **66% White**
- **7 wards (of 18) are amongst the most deprived in England**
- **Smoking prevalence of 33%**
- **42% of people who have accessed the stop smoking service have successfully quit**

6.2 Neighbourhood 1

The PCT has divided Lewisham into four geographical areas called Neighbourhoods. Neighbourhood 1 (N1) consists of 4 wards: Evelyn, Telegraph Hill, New Cross and Brockley.

The Health Profile for N1[31] gives the following insight:

6.2.1 Population

There is a diverse mix of ethnic groups in Neighbourhood One (N1). In particular, it has a larger population of Black African, Black Caribbean and Chinese Ethnic Groups than the other neighbourhoods. The Black African and Chinese Ethnic Group in Evelyn ward is double the Lewisham average.

- N1 contains two of the most deprived wards in the whole borough (Evelyn and Grinlyn Gibbons (old ward boundaries).
- N1 has the highest number of under 5s in the borough.
- The wards in N1 have the highest fertility rates (particularly Evelyn), when compared to the other three neighbourhoods.

6.2.2 Socio-economic indicators in N1

[31] http://www.lewishampct.nhs.uk/document_view.php?DID=00000000000000000180

- There are a high proportion of single pensioner households, particularly in New Cross and Evelyn wards.
- More householders rent from the local council than own their own homes.
- 40% of households with dependant children in N1 are headed by a lone parent and 35% have no parent in employment.
- N1 has the highest levels of unemployment in the borough.

In addition, N1 housed the largest number of asylum seekers claiming subsistence as at October 2003. Chinese, Vietnamese, Afghans and Somalians are more concentrated in N1.

6.2.3 Health in N1

- N1 residents have poorer self-reported health than the national average.
- Life expectancy at birth is lower in all N1 wards than in London.
- N1 has high levels of infant mortality, double the national rate in some wards.
- N1 has a high percentage of low birth weight babies, particularly in New Cross, Evelyn and Telegraph Hill.
- All causes of mortality rates are well above the national average.
- Premature deaths from all causes are also higher than the national average.
- When compared to the other neighbourhoods, N1 has the highest number of hospital admissions by people aged 50 years and above for heart failure, emergency admissions and hip fractures. It also has the highest number of avoidable admissions.
- Children have poorer oral health and are less likely to receive dental care when compared to the other neighbourhoods.
- N1 has the highest asthma hospital admission rates in London, twice as high as the national rates. In comparison to the rest of Lewisham, admission rates in children are lower in N1 but rates in the elderly population are substantially higher than other parts of Lewisham.
- N1 has the highest fertility rates compared to the other three neighbourhoods.
- N1 has the highest admission for heart failure and the lowest for angina among the neighbourhoods.
- In people over 50, N1 has higher than average admissions for hip fracture, heart failure, avoidable and emergency admissions (April 2000 – March 2003).
- The highest numbers of diagnoses of gonorrhoea were evident in the northern and western parts of the borough (where N1 lies).

It is interesting that older people in N1 receive less social care provision than the borough average. They receive less day care, home care and meals on wheels from the Local Authority.

The Queens Road Practice has clients in the N1 area. It's 2006 Health Profile throws up some interesting facts:

- There is poor uptake of breast screening services amongst Queens Road clients. There is only 77.1% coverage of screening for cervical cancer across Lewisham in 2001-2. Although higher than the London rate of 75.9%, it is lower than the national rate of 81.6% and shy of the national 80% target. This may suggest an unwillingness of certain parts of the population to actively

consider ill-health prevention or to engage with health professionals for ill-health prevention.

- In 2003/4 the uptake of influenza immunisation for people aged 65 and over was only 58%, well shy of the 70% national target.
- New Cross and Evelyn have a 50% higher mortality for circulatory disease in <75s than the rest of London.
- There are a higher number of underweight males and females and higher obese women than national figures. This may be explained by ethnicity and deprivation factors.
- The QRP area has a lower than national prevalence of CHD, LVD, COPD, epilepsy, cancer and hypothydroidism. It has an average national prevalence factor in CVA/TIA, BP, DM and MH.
- In relation to neighbouring practices, it is average for DM, epilepsy and MH but in all the other disease groups it is above average to neighbouring practices.
- There is higher antidepressant prescribing than neighbouring practices. Given the link between smoking and mental health, this could also be important.

6.2.4 Smoking in N1

According to ASH, the smoking rates for the 4 wards of N1 are as below:

	Prevalence amongst men	Prevalence amongst women	Total prevalence
Brockley	41	31	36
Telegraph Hill	40	30	35
Evelyn	49	35	42
New Cross	46	33	39
Average	**44**	**32**	**38**

N1 summary

- **Smoking prevalence of 38%**
- **44% prevalence for men, 32% prevalence for women**
- **Poor uptake of health screening services**

6.3 Introduction to Evelyn

Evelyn, New Cross and Brockley all fall within the top 5 most deprived wards in Lewisham and within the top 30% nationally. Evelyn's score falls within the nation's top 20% most deprived wards.[32] According to the 2001 census, the population of Evelyn was 14,512 in 2001.

6.3.1 Population

Age

The average age of Evelyn residents is approximately 30.7 years. This is considerably lower than the borough average of 34.7 years. Evelyn has a higher than average social dependency ratio. This ratio reflects the high numbers of children in the ward.

[32] Queens Road Partnership Health Profile, June 2006.

Ethnicity

The BME population comprises 54.8% of Evelyn's resident population[33], compared with an average of 34% across the borough. The largest single BME populations are Black African (25.1%) and Black Caribbean (10.4%). Evelyn ward has the highest proportion of black and minority ethnic (BME) residents in the borough.[34] The Black African and Chinese Ethnic Group in Evelyn and New Cross ward are double the Lewisham average. According to the 2001 census, Evelyn and surrounding wards have the following ethnic makeup:

	% population in each ethnic group							
Wards in N1	White Ethnic Group	Mixed Ethnic Group	Asian Ethnic Group	Black Caribbean Ethnic Group	Black African Ethnic Group	Black Other Ethnic Group	Chinese Other Ethnic Group	Other Ethnic Groups
Brockley	60.1	4.43	3.55	14.12	11.77	2.75	1.52	1.96
Evelyn	45.2	4.2	3.23	10.38	25.12	2.67	4.68	4.54
New Cross	47.3	4.68	3.66	14.27	19.41	2.83	4.03	3.78
Telegraph Hill	58.1	4.71	2.43	15.8	13.32	3.08	1.07	1.5
N1	52.48	4.49	3.22	13.64	17.51	2.83	2.86	2.97
N2	70.01	4.13	4.49	11.19	6.31	1.81	1.08	0.98
N3	71.42	3.81	3.92	12.02	5.62	1.77	0.74	0.70
N4	65.58	4.32	3.66	12.17	7.53	1.91	1.01	0.82
Lewisham	65.92	4.17	3.79	12.27	9.07	2.07	1.38	1.32
London	71.15	3.16	12.09	4.79	5.28	0.84	1.12	1.58

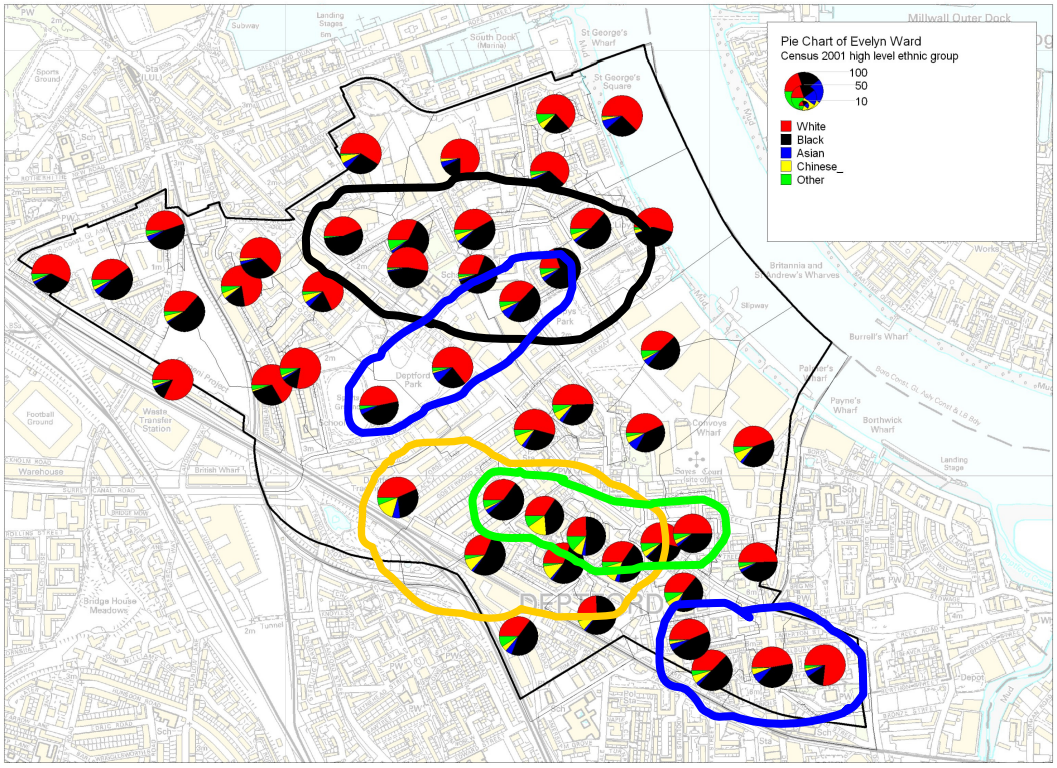
In addition it is useful to look at the numbers of first and second generation members of the BME population by examining countries of birth[35]:

Country of birth	Ward proportion	Lewisham proportion	London proportion
UK	63.5%	76.1%	72.9%
Rest of Europe	5.9%	5.5%	7.1%
Africa	16.1%	6.7%	6.3%
Asia	8.5%	5.1%	8.9%
Caribbean	4.1%	4.6%	2.0%

From this table we can see that many more than the Lewisham or London populations were born in Africa. This may have considerable implications for social marketing in terms of language and cultural differences.

The map below shoes the distribution of BME members throughout the ward. It is clear that there are no significant single-ethnicity groups (which may become insular and ghetto-d) but that there are areas in which a high density of a particular ethnic group live alongside smaller representatives of other group. Integration seems to be fairly consistent in the ward:

[33] Evelyn, a ward profile: Summary of information.
[34] Evelyn, a ward profile. Summary of information.
[35] Evelyn, a ward profile: Summary of information



It is of interest that there is a high demand for Vietnamese speaking face-to-face interpreters at the Queens Road Practice (30%) followed by 27% Somali speaking and 14% Turkish. This is in contrast with telephone interpreters, of which 15% of those required are Spanish, 20% Vietnamese and 26% Somali. This suggests that Spanish-speaking patients are accessing services differently from the other non-English speaking ethnic groups.

Religion

	Ward number	Ward Proportion	Rank in borough	Lewisham proportion	London proportion
Christian	8472	58.4%	14th	61.3%	58.2%
Buddhist	641	4.4%	1st	1.1%	0.8%
Hindu	175	1.2%	14th	1.7%	0.8%
Jewish	26	0.2%	14th	0.3%	2.1%
Muslim	1061	7.3%	1st	4.6%	8.5%
Sikh	14	0.1%	16th	0.2%	1.5%
Other religions	65	0.4%	11th	0.5%	0.5%
No religion	2475	17.1%	16th	20.4%	14.8%
Not stated	1583	10.9%	5th	10.1%	8.7%

The most significant non-Christian religion is Islam, so Ramadan will potentially be an important festival for smoking cessation interventions. Ramadan is the ninth month of the Islamic Lunar calendar and the holiest of the four holy months. It begins with the sighting of the new moon after which all physically mature and healthy Muslims are obliged to abstain from all food, drink, gum chewing, any kind of tobacco use, and any kind of sexual contact between dawn and sunset. Purity of

thought and action is paramount. Ordained in the Quran, the fast is an exacting act of deeply personal worship in which Muslims seek a raised level of God-consciousness.[36] However, anecdotally it has been commented that some overcompensation by Muslim smokers can take place, whereby tobacco is binged after nightfall to make up for the daytime abstinence.

6.3.2 Socio-economic indicators

Evelyn is the most deprived ward in Lewisham. Economic activity at 63% is the second lowest in the borough with unemployment at 8% the highest rate compared with a borough average of 5.5%. Including the economically inactive residents the unemployment has been classified as 11.9%, the highest in the borough)[37]. Also, life expectancy is currently 75 years, the fourth lowest in the borough, although this is recognised to be a fluid measure and is more likely to be a reflection of socio-economic and migration patterns that contribute to health.

Economic snapshot

Indicator	Rank in borough	Comparison
Percentage economically active: 63.0%	17th	**68.9% Lewisham 67.6% London**
Full time employment rate: 37.0%	18th	**43.5% Lewisham 42.6% London**
Unemployment rate: 8.1%	1st	**5.6% Lewisham 4.4% London**
Long-term unemployment rate: 2.6%	1st	**1.9% Lewisham 1.4% London**
Youth unemployment rate: 7.6%	5th	**7.3% Lewisham 5.3% London**
Number working to retired: 8.2 to 1	5th	**6.9 to 1 Lewisham 4.5 to 1 London**

This table gives an overall picture of the economic deprivation of Evelyn. Of particular note are the unemployed and long-term unemployed rates. The psychological consequences of unemployment and long-term unemployment will have considerable impact over the ward's smoking prevalence.

Although N1 has a higher proportion of people with qualifications than the Lewisham average, in Evelyn, the number of people without qualifications is higher than those with qualifications (N1 - A Profile). 29.4% of Evelyn residents have no qualifications – the fourth highest level in the borough. Only 25.5% have a degree or equivalent compared to 29.4% of Lewisham and 31% in London. BME individuals are more likely to be educated to some form than the general population. This trend continues up to degree level, with BME individuals more likely to be educated up to this standard.

Ward	Total number of people	% without qualifications	% qualified to degree level or higher (including vocational quals)

[36] http://www.ramadan.co.uk/index1.php?page=others.htm

[37] Evelyn, a profile: Summary of information

Brockley	10,650	20	38
Evelyn	10,102	29	26
New Cross	11,138	24	28
Telegraph Hill	10,857	23	34
N1	42,747	24	32
N2	39,795	20	39
N3	39,795	20	39
N4	52,184	24	iii. 27
London	5,300,332	24	31
England	35,532,091	29	20

Perhaps unsurprisingly, therefore, N1 has the highest proportion of unemployment of all the neighbourhoods and Evelyn has the sixth highest incidence of youth unemployment in the borough at 7.6%. Long-term unemployment is also a major issue with 2.6% of the working age population being out of work for the past two years, compared with an average of 1.9% in the borough.

Wards	**% unemployed**	**% permanently sick or disabled**
Brockley	8.28	5.46
Evelyn	9.99	5.79
New Cross	9.52	5.66
Telegraph Hill	8.77	5.53
N1	9.1	5.6
N2	6.3	4.7
N3	6.3	5.4
N4	7.0	5.2
Lewisham	7.2	5.3
London	5.5	5.0
England and Wales	4.3	6.1

The table below shows that AB, the highest social grade, is well below average while there is a much higher than borough average proportion in the social grade E.[38] Evelyn has a sizeable proportion of residents classed as being in routine/semi-routine (20.4%) occupations compared to the borough as a whole, and a low proportion in the managerial/professional group (22.6%).

	Ward number	**Ward proportion**	**Rank in borough**	**Lewisham proportion**	**London proportion**
Managerial/professional	2282	22.6%	17th	32.7%	34.3%
Intermediate/supervisory	1992	19.7%	15th	21.9%	21.6%
Routine/semi-routine	2057	20.4%	3rd	16.2%	14.8%
Unemployed	1198	11.9%	1st	6.5%	6.0%
Students	1396	13.8%	3rd	9.4%	9.0%
Other	1177	11.7%	14th	13.3%	14.2%

[38] Evelyn, a profile: Summary of information

This table also shows again that unemployment is a considerable problem in Evelyn and that there are more routine/semi-routine workers and students than many other boroughs. This will contribute to the low income of the ward and consequently to its deprivation levels. For males, Evelyn has almost double the unemployment levels in London.

As well as unemployment, deprivation in Evelyn due to low income levels can also be attributed to the large number of

6.3.2.1 single pensioner households in Evelyn

6.3.2.2 rented local council accommodation:

Wards	**% owner occupied**	**% rented from Local Authority**
Brockley	37.4	26.1
Evelyn	19.6	58.9
New Cross	29.4	42.8
Telegraph Hill	39.4	34.3
N1	31.4	40.6
N2	53.2	19.4
N3	59.9	23.1
N4	53.4	24.1
Lewisham	50.1	26.6
London	56.5	17.1
England and Wales	68.9	13.2

- Levels of owner occupation as a form of household tenure are the lowest for the borough at 20%, compared with a borough average of 50%.
- 32.1% of homes are overcrowded. Overcrowding is a serious problem in Evelyn and affects this ward disproportionately in comparison with other wards in the borough.
- Housing quality, however, was amongst the best in the ward and may indicate the overall quality of council housing.

    - households with dependent children
    - households with dependent children headed by a lone parent
    - households with dependent children headed by no working adult
    - 15% of residents having a limiting long-term illness (compared with a borough average of 16%).

Introduction to Evelyn: a summary

- **45% white ethnic group and 55% BME population**
- **Most deprived ward in Lewisham**
- **Highest unemployment in Lewisham**
- **High council rented tenure**
- **Many low income households**

6.3.3 The physical environment in Evelyn

Evelyn is a visibly deprived ward but with some clear evidence of regeneration. Evelyn street is a strip of shops, including supermarkets, Vietnamese and Chinese takeaways and restaurants, betting shops and pubs. Deptford High Street is similar but with a few cafes and lots of hair dressers. The photographs below shows the John Evelyn pub on the corner of Grove Street and Evelyn Street (and a smoking ban advert in the foreground) and a selection of the Vietnamese cafes across the road on Evelyn Street:

Some of the shops appear to be closed. The Sure Start unit near the Cost Cutter supermarket on Evelyn Street has a sign in the window saying it has closed due to persistent burglaries:

Community organisations and shops off Evelyn Street

Dr Hashmi (next door, visible in the photograph above) has a reception which is separate to the waiting room so that people go in and talk through a glass partition before they are admitted to the waiting room. This is unfriendly and unwelcoming but presumably safer for staff.

Away from these two commercial centres are the accommodation areas, which mainly comprise high rise and low rise flats and maisonettes. Some are visibly run down with flecking paint and long grass. Others are well kept and modern looking.

The modern Pepys flats overlooking the old football pitch appears to be very modern and smart. They are unfinished (photo below) but reportedly have good sized rooms and are well designed. As can be seen, the football pitch is now just a grassed over park.

New Pepys Flats with Aragon Tower in the background and Pepys Park in the foreground

The Aragon tower, (which has been sold off for private development and resale), overlooks the Thames and Thames Walk, which will be developed so residents can walk along the river all the way to Greenwich. It is visible in the background of the photograph above. This is a delightful area, with great views of the financial quarter and Canary Wharf. The tower looks like a New York city apartment block rather than an ex-council tower block.

Pepys Community Forum attempted to set up and arts centre on the first few floors of the Aragon but this plan has ground to a halt.

The area by the river is clean and spacious and attractive. It includes the Pepys Resource Centre, which was an employment centre but is defunct and has been closed for 4 years.

Further away from the river the estates are less welcoming. These were pictured on Grove Street near Evelyn Street:

There is little evidence of a serious litter or graffiti problem although some is evident. The police commented (at the Evelyn Neighbourhood Management Panel) that there is a significant drug dealing problem in the park behind Sayer's Park at the back of Evelyn Street. There is a pattern of street drinkers inhabiting a place and then it being taken over by drug dealers. The street drinkers have now been displaced by a series of drug dealers. The police are working on initiatives to catch them dealing. Catching them possessing drugs is not enough to stop the problem.

Lewis Herlitz commented that a major local concern is the scrap yard and it is easy to see how the noise and dust from this enterprise, along with abandoned car and car parts in the vicinity would pose a concern:

A focus group[39] with Indo-Chinese residents of social housing was conducted to discuss housing issues. Useful insights can be gained. These include the following:

- The Repair Service is poor. Participants made complaints that appointments were often broken and follow up appointments (where a part was being waited for) often never happen. Participants were also left confused about who was responsible for what and what was included on the repairs schedule.
- Generally participants felt that the caretaking service in their area and to their blocks had improved slightly.
- Participants felt that the upkeep of green and open spaces was generally good but felt that trees were left to over grow and cause damage.
- Participants felt that much of the anti-social behaviour in the area was due to the lack of facilities for young people in the area, this led to young people to hang around stairwells, gather in seating areas and play football in enclosed areas. Suggestions were for more designated areas for young people to play sport and also increased signage. Some participants said that they had experienced anti-social behaviour from residents who didn't care for their homes and their environment and who didn't dispose of rubbish properly.
- When this group was asked what they thought of the Warden Service, they said that they did not know what the wardens were or what they looked like. Even after explaining the wardens role to them and describing the Wardens 'uniform', the group said that they had never seen them.

[39] http://www.lewisham.gov.uk/NR/rdonlyres/50C0FF4F-BD2B-4647-B537-59FECCCC82A8/0/IndoChinesefocusgroupreport7306.pdf

- Half the participants agreed this was a problem for them with vehicles being dumped in their streets. Although they didn't know who to report the dumped vehicles to, they did observe that the Council were very quick to remove them.
- A couple of participants reported this being a problem where they live but said that the Council were very quick to remove the graffiti.

Other comments from community workers has shed light on the following insights

- Numerous tower blocks
- Recent regeneration
- Some but not serious graffiti
- Some but not serious antisocial behaviour
- Some but not serious crime
- Recent influx of gang crime
- General unhappiness with the scrap yard.

6.3.4 Smoking in Evelyn

The table below shows that six wards appear to have a smoking prevalence higher than the 33% Lewisham average, with Evelyn ward being the highest at 42% (Miller, 2006)[40].

Lewisham Ward	Estimated percentage of population over 16 smoking
Bellingham	37
Blackheath	31
Brockley	36
Catford South	23
Crofton Park	29
Downham	38
Evelyn	42
Forest Hill	32
Grove Park	31
Ladywell	30
Lee Green	29
Lewisham Central	32
New Cross	39
Perry Vale	31
Rushey Green	31
Sydenham	33
Telegraph Hill	35
Whitefoot	33

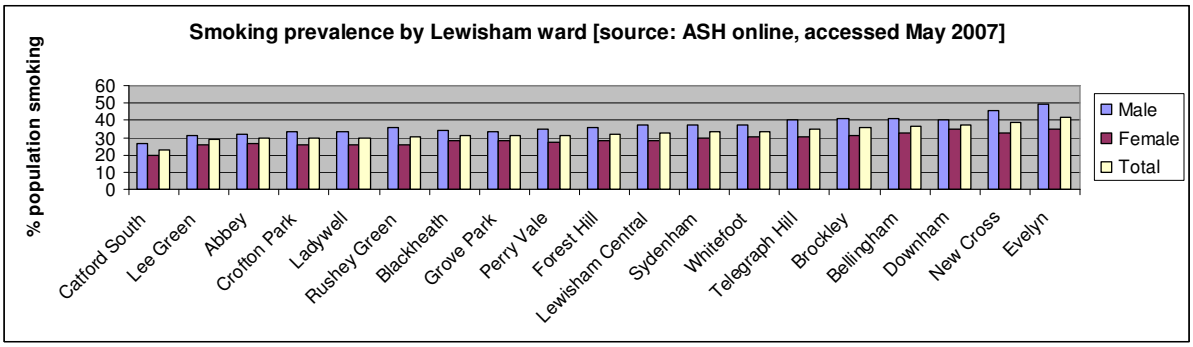
Source: Twigg, Moon and Walker (2004)

The table below, from ASH, suggests that the male smoking rate is 49% and the female smoking rate is 35%. This compares ill-favorably with the national smoking rate for men of 26% and women of 23%.

40 These data represent a reasoned, robust 'best guess' as to smoking prevalence (Miller, 2006)

	Male	Female	Total
Catford South	27	20	23
Lee Green	31	26	29
Abbey	32	27	29
Crofton Park	33	26	29
Ladywell	34	26	30
Rushey Green	36	26	31
Blackheath	34	28	31
Grove Park	33	28	31
Perry Vale	35	27	31
Forest Hill	35	28	32
Lewisham Central	37	28	32
Sydenham	37	30	33
Whitefoot	37	30	33
Telegraph Hill	40	30	35
Brockley	41	31	36
Bellingham	41	33	37
Downham	41	35	38
New Cross	46	33	39
Evelyn	49	35	42

As this graph shows, Evelyn has the highest smoking rate in Lewisham:



This table shows estimated percentages (from the Lewisham Quality of Life Survey 2004) of numbers of residents who wish to quit smoking:

Ward	**Percentage of those smoking who wish to give up**
Bellingham	63%
Blackheath	54%
Brockley	71%
Catford South	78%
Crofton Park	76%
Downham	50%
Evelyn	68%
Forest Hill	80%

Grove Park	57%
Ladywell	48%
Lee Green	72%
Lewisham Central	70%
New Cross	71%
Perry Vale	81%
Rushey Green	70%
Sydenham	62%
Telegraph Hill	66%
Whitefoot	68%

It is of note that the 68% level given from Evelyn is not as high as expected. Perry Vale has an estimated smoking rate of 31% and yet has an estimated 81% of the population wanting to quit.

Smoking in Evelyn: a summary

- **42% smoking rate overall**
- **49% smoking rate for men**
- **35% smoking rate for women**
- **68% wish to give up smoking**

6.3.5 Health in Evelyn

N1 residents reportedly have the poorest self-reported health than the national average:

Ward health status

	Ward number	**Rank in borough**	**Lewisham proportion**	**London proportion**
General health – good	10167 (70.1%)	8th	69.2%	70.8%
General health – fairly good	3155 (21.7%)	12th	22.4%	20.9%
General health – not good	1190 (8.2%)	9th	8.5%	8.3%

- Evelyn and New Cross wards have 20% higher levels of limiting long-term illness than London and nationally. 14.6% of people have a limiting long-term illness and 13.5% of working age people have a limiting long-term illness.
- Evelyn has among the highest levels of gonorrhoea in Lewisham.
- Evelyn has the second highest under 18 conceptions in N1.

Key data from the N1 Health Profile is highlighted below and a suggested link with smoking is presented:

There is higher antidepressant prescribing from Queens Road than neighbouring practices.	Smoking is known to be linked with depression. Some researchers have concluded that the effects of long-term nicotine exposure on the brain may cause depression while others suggest that individuals predisposed (environmentally or genetically) to depression may also be predisposed to smoking.
Evelyn has nearly three times the national levels of infant mortality. The national rate for England and Wales is 3.9 for neonatal mortality per 1000 live births and 5.8 for infant mortality per 1000 live births. Evelyn's rate is 9.5 for neonatal mortality and 15.4 for infant mortality.	The link between infant mortality and smoking has been proven. A rigorous US study by Kleinman *et al*[41] estimated that if all pregnant women stopped smoking, the number of foetal and infant deaths would be reduced by approximately 10%
All causes of mortality rates in N1 are well above the national average – New Cross and Evelyn wards have the highest rates for males and females respectively (49-68% higher than the national average). Evelyn's mortality ratio for all persons is 124.3 compared with 116.1 for Lewisham and 100.8 for London. Evelyn's life expectancy at birth (1998-2001) is 71.6 years for males and 78.5 years for females, which is low compared with the 75.4 years for males and 80.3 years for females in London. Evelyn has a particularly large difference in life expectancy between men and women (71.6 years for men and 79.3 years for women).	ASH tells us that one in two long-term smokers will die prematurely as a result of smoking – half of these in middle age. The most recent estimates show that around 114,000 people in the UK are killed by smoking every year, accounting for one fifth of all UK deaths. Given Evelyn's high smoking rate of 42%, this is likely to be a major cause of mortality in the ward.
When compared to the other neighbourhoods, N1 has the highest number of hospital admissions by people aged 50 years and above for heart failure.	The BMJ[42] tells us that In the UK, about 1 in 8 deaths from heart disease happen because of smoking. Researchers have found that nicotine and other chemicals in cigarette smoke damage the lining of the arteries, and these chemicals also make blood more likely to clot.

[41] Kleinman, Jc; Pierre M; Madans J; Land, G & Schramm, W; (1988). American Journal pf Epidemiology Vol. 127, No. 2: 274-282.

[42] http://www.besttreatments.co.uk/btuk/conditions/22373.html

Life expectancy at birth is lower in all N1 wards than in London.	Doll's famous 50 year study[43] of doctors found that smoking lowered life expectancy by 10 years and that stopping smoking at ages 30, 40, 50 and 60 increased life expectancy by around ten, nine, six and three years, respectively. The high smoking rate in Evelyn is likely to contribute to the low life expectancy of the area.
N1 has a high percentage of low birth weight babies, particularly in New Cross, Evelyn and Telegraph Hill.	ASH tells us that babies born to women who smoke are on average 200 grams (8 ozs) lighter than babies born to comparable non-smoking mothers. The high smoking prevalence, therefore, may explain the low birth weight babies in Evelyn.
N1 has the highest asthma hospital admission rates in London, twice as high as the national rates.	Asthma is known to be linked to smoking and passive smoking, which may explain the high rates of hospital admissions from asthma in N1.
Evelyn's premature death rate from cancer for all ages is 108.4 compared with the London average of 98.5. (The Lewisham average is higher still at 112.2.)	Ssmoking is an important cause of cancers of the lung, larynx (voice box), pharynx (throat), oesophagus, bladder, kidney and pancreas. A recent review found that, in addition to these cancers, smoking is a cause of cancer of the nasal cavities and sinuses, stomach liver, cervix and myeloid leukaemia. Evelyn's high smoking prevalence may be contributing to the higher than expected cancer prevalence.

[43] http://www.mrc.ac.uk/YourHealth/StoriesDiscovery/Smoking/index.htm

Summary

- National prevalence is 25%
- Lewisham prevalence is 33%
- N1 prevalence is 38%
- Evelyn prevalence is 42%

- April – September 2006 nationally, 51% of those setting a quit date successfully quit
- 42% of people in Lewisham who accessed the stop smoking services have successfully quit
- The following chapter discusses National and local smoking cessation provision in more detail

7.0 Smoking Cessation

All PCTs are required to participate in a local health services patient survey. In the survey for 2005, the national average showed 40% of current smokers had been offered help or advice to stop smoking by someone at their GP surgery/health centre over the 12 month period prior to the survey.

7.1 National rates

Key results from *Statistics on NHS Stop Smoking Services in England, April to September 2006* show that in England during the period April to September 2006:

- 246,254 people set a quit date through NHS Stop Smoking Services.
- At the 4 week follow-up 124,803 people had successfully quit (based on self-report), 51% of those setting a quit date. This compares with 142,188 successful quitters in the same period in 2005 (a decrease of 12%).
- Of those setting a quit date, success at the four-week follow up increased with age, from 36% of those aged under 18, to 60% of those aged 60 and over.
- The majority of those setting a quit date received Nicotine Replacement Therapy (NRT) only (83%). A further 5% received bupropion (Zyban) only and 1% received both NRT and bupropion.
- Of the 8,171 pregnant women who set a quit date, 4,141 successfully quit at the 4 week follow-up (51%).
- Among Government Office Regions (GORs), the South East reported the highest proportion of successful quitters (56%), while the North East and North West reported the lowest success rate (46%).
- Bedfordshire and Hertfordshire Strategic Health Authority (SHA) had the highest proportion of successful quitters (65%), while Cheshire and Merseyside SHA reported the lowest (42%).
- The expenditure on NHS Stop Smoking Services was £26.3 million. This does not include the cost of NRT or bupropion on prescription. This compares to £23.2 million in the same period in 2005.
- The cost of the NHS Stop Smoking Services per quitter was £189, compared with £163 during the same period in 2005/06.

Summary

- **In 2005, 40% of smokers were offered help or advice to stop smoking by someone at their GP surgery**
- **From April – Sept 06, 51% of those setting a quit date successfully quit. This figure increases with age.**
- **Most people quit using NRT**
- **51% of pregnant women who set a quit date successfully quit**

7.2 Smoking cessation in Lewisham

The stop smoking service programme operates at 3 levels:

Level 1

Provision of information about smoking and health and services available to help smokers to quit (provided by any professional). Also known as brief interventions.

Level 2

Clients are offered one-to-one consultations and telephone counselling. Advisers support clients by helping them to understand addiction, using motivational techniques and educational and self-help materials. They are also helped to choose an appropriate method to help them quit, eg. nicotine replacement products or bupropion.

Clients are monitored by telephone or letter at four weeks after their quit date and the outcome is recorded. Carbon monoxide measurement is carried out where possible to validate reported success.

Relapse is often part of the quitting process and clients may make several attempts before becoming confidently smoke free. If their initial attempt is unsuccessful they are encouraged to re-register with the service when they are ready (not less than six months since their last quit attempt).

Across Lewisham there are currently 29 General Practices and 30 pharmacies providing a level 2 service. Other Level 2 service provision includes:

- various workplaces
- the Walk-In Centre
- Neighbourhood Clinics
- a service for pregnant women and young families
- with community groups

Level 3: Specialist Smoking Cessation Clinic.

This service is provided at the main site in Camberwell and two satellite sites within Lewisham. More than three quarters of the people receiving treatment are seen in groups. The remainder are advised on a one to one basis. Almost 50% of those setting quit dates did so at the two satellite sites, each with only one session per week.

7.3 Quit success rates

The following chapter breaks the service down into the Level 2 and 3 services for Lewisham. All the data is taken from Miller (2006), the Health Equity Profile analysis for Lewisham.

7.3.1 Level 2 quit rates

Data from the Level 2 Stop Smoking Service database was examined for the six calendar years from 2000 to 2005:

Quit Status	2000	2001	2002	2003	2004	2005	All Years
No	21	126	209	157	125	193	831

Not Stated	46	152	345	325	438	680	1986
Yes	28	185	349	253	380	599	1794
Total No. of Quit dates set	95	463	903	735	943	1472	4611
Quit rate	29%	40%	39%	34%	40%	41%	39%

- There were 4611 quit dates set through the Level 2 Stop Smoking Service from January 2000 to December 2005. The number of quit dates set increased steadily during this period, with a dip in 2003.

- The average quit rate was 39%. Over the six year period the quit success rate has increased from 29% to 41%, with a dip in 2002 and 2003.

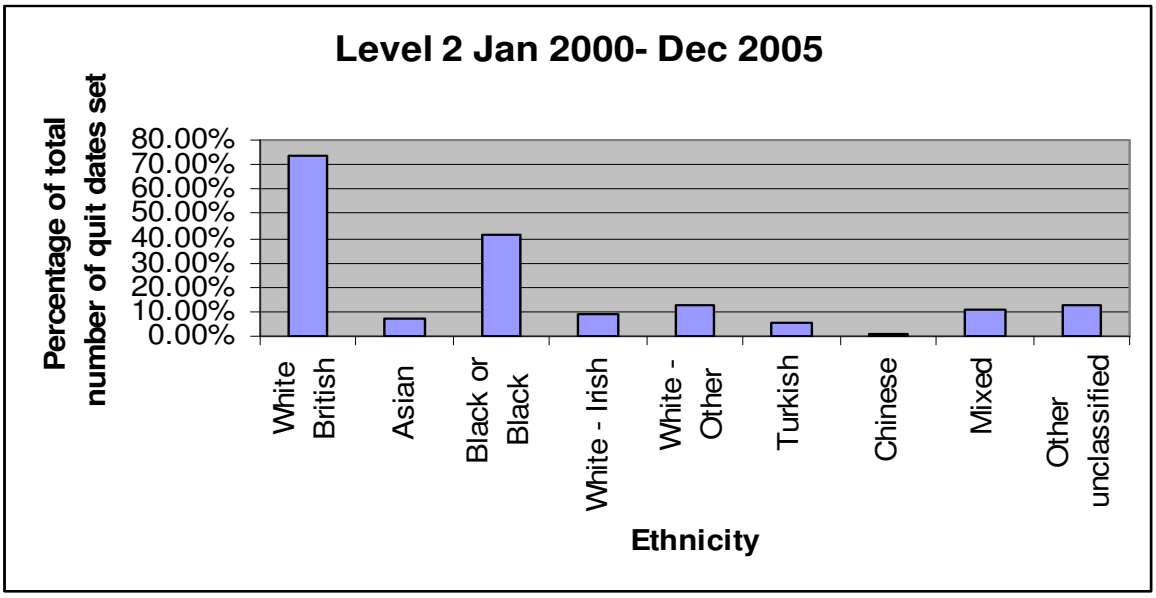
7.3.2 Gender

Across Lewisham, a far greater number of quit dates were set by women (62%) than men (38%). Both genders have the same quit rate at 39%.

7.3.3 Ethnic Groups

Nearly 80% of the quit dates were from the white population. The next largest group was the Black population including Black British Caribbean, Black British African and Black other with 11% of the total. Black Caribbean was the largest of these three, with more than 7% of the total number of quit dates set. More than 2% of the total number of the quit dates set were from the White Irish population, while less than 2% were from the Turkish population:

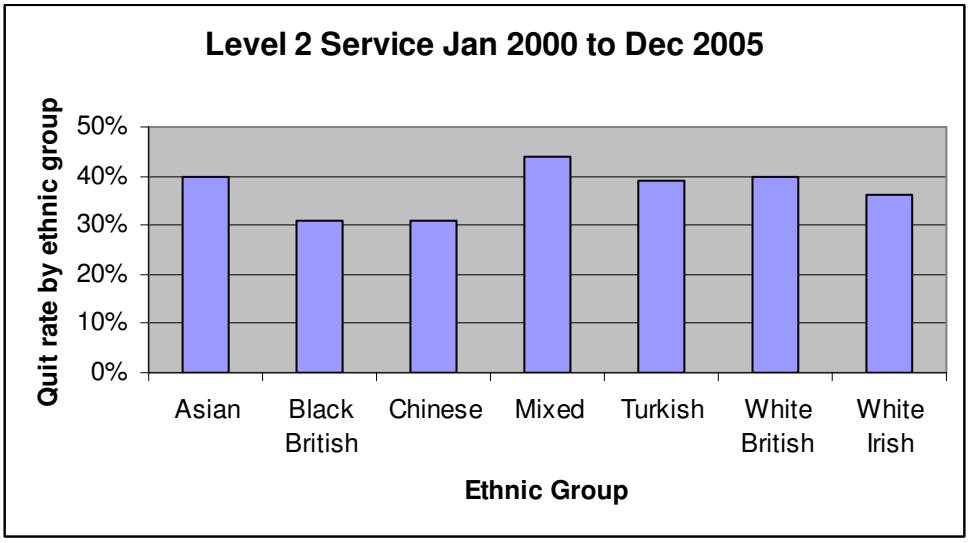
A breakdown by ethnicity of quit dates set



Ethnic group	Quit dates set	
Asian or Asian British - Bangladeshi	10	0.22%
Asian or Asian British - Indian	34	0.74%
Asian or Asian British - Other	36	0.78%
Asian or Asian British - Pakistani	10	0.22%
Black or Black British - African	92	2.00%

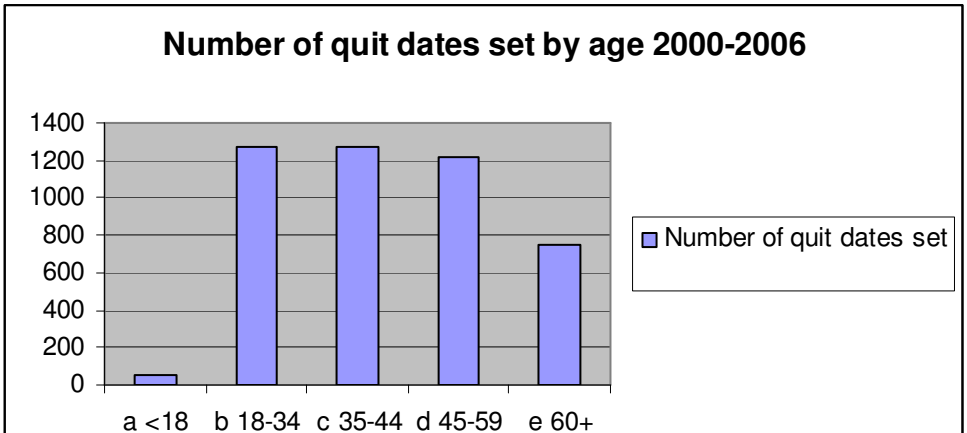
Black or Black British - Caribbean	328	7.11%
Black or Black British -Other	84	1.82%
Mixed – Other	35	0.76%
Mixed - White/Asian	12	0.26%
Mixed - White/Black African	18	0.39%
Mixed - White/Black Caribbean	66	1.43%
White – British	3405	73.85%
White – Irish	103	2.23%
White – Other	147	3.19%
Turkish	66	1.43%
Chinese	13	0.28%
Other unclassified ethnic group	89	1.93%
Refused to give	63	1.37%
	4611	100.00%

- The mixed group has the highest quit rate at 44%
- The Black British group is the lowest at 31%.
- The number of Chinese people setting a quit date was very low (12), therefore the quit rate should be interpreted with caution.
- The average quit rate for the general population in Lewisham Level 2 service is 39%.

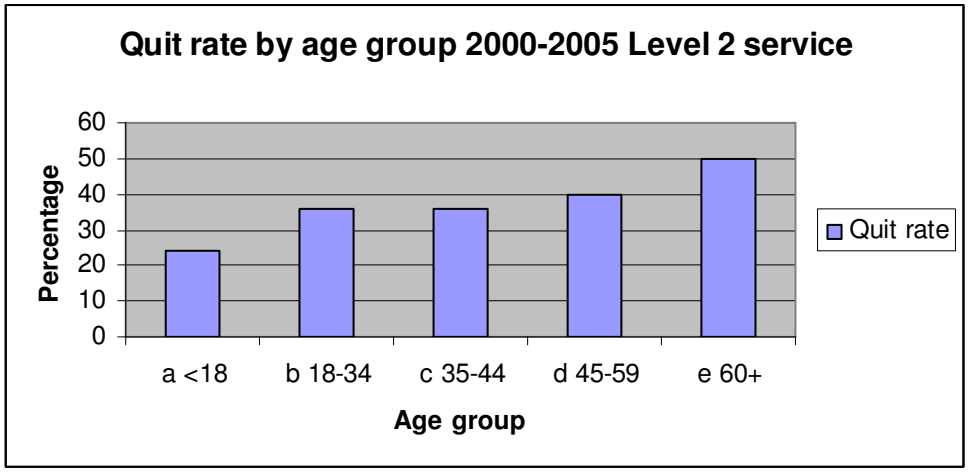


7.3.4 Age

- The number of quit dates set between 2000 and 2005 are highest in the people aged 18 to 59.



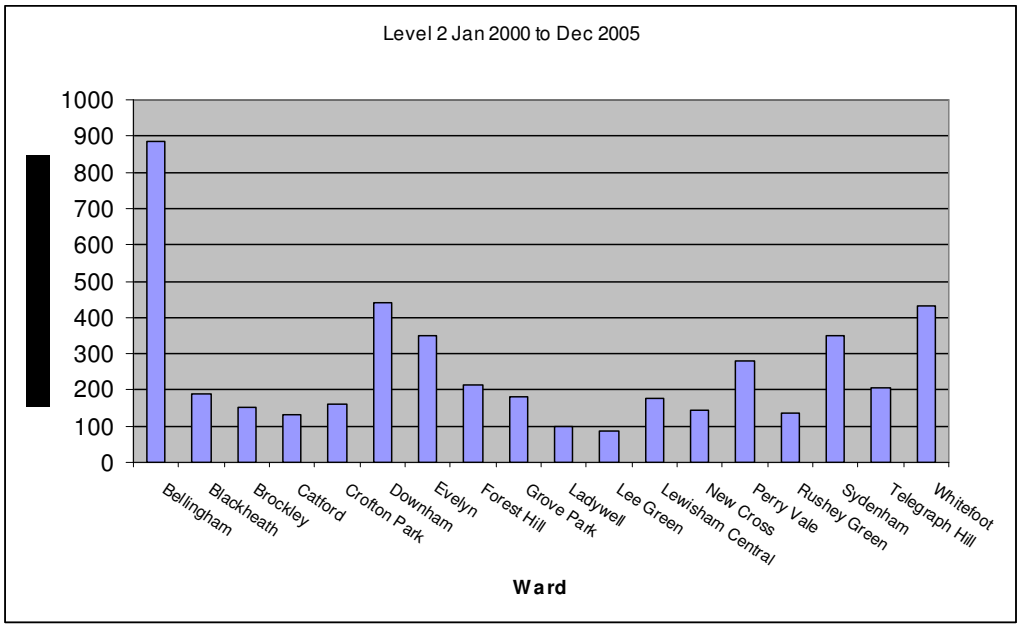
- The three age groups, 18 to 34, 35 to 44 and 45 to 59 all have similar numbers of quit dates set.
- The lowest age group for quit dates set are young people under the age of 18.



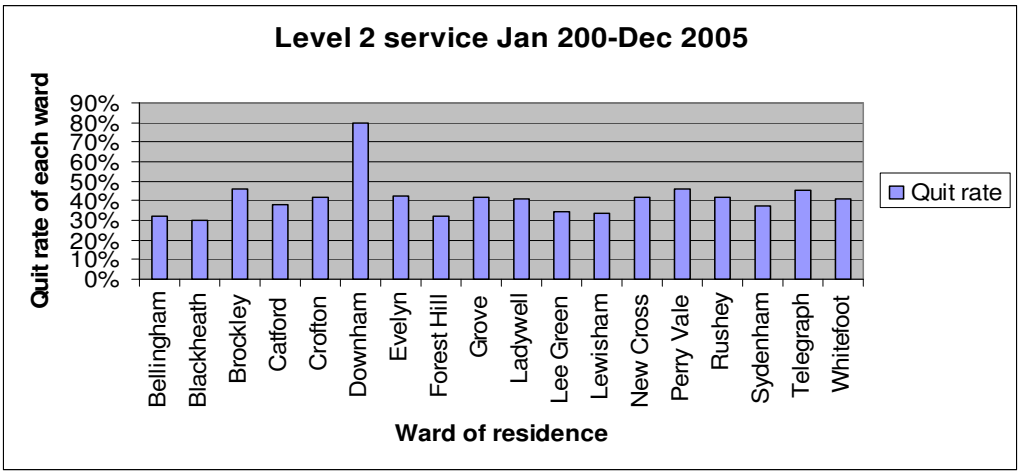
The quit rate increases with age, with 50% of those aged above 60 successfully quitting at four weeks. The numbers of people under 18 setting a quit date low and only 24% of them succeed.

7.3.5 Ward breakdown

There is quite a lot of variation between the wards. The number of quit dates set in Bellingham is far higher than in any other ward. The number of quit dates set in Bellingham is more than twice that of Downham and Whitefoot, which also have high numbers of quit dates set. The lowest number of quit dates set was in Lee Green. Evelyn has a respectable number of quit dates set.



The graph below shows the quit rates for the Level 2 service. Downham had a very high success rate at 80% and Blackheath the lowest. Evelyn again scored respectably.



7.3.6 Pregnant women

Only a total of 61 quit dates were set by pregnant women in the past six years. Those who do set a quit date, however had a high quit success rate at 46%.

Level 2 service summary

- **In 2005, success rate was 41%**
- **Women set far more quit dates than men**
- **80% of quit dates set were by the White population**
- **The Mixed group has the highest quit rate, the White population the lowest**
- **There was considerable variation amongst the wards**
- **Few pregnant women set quit dates**

7.3.7 Level 3[44] quit rates

The total number of quit dates set at the Specialist Clinic between April 2001 and March 2005 was 1051, with more than 50% of the quit dates set by women. 67% of the quit dates set led to a successful quit.

7.3.8 Gender

Gender	% quit dates set (n)
Males	41.3 (434)
Females	58.7 (617)

The quit success rate for men and women was very similar with 66% of men and 67% of women setting quit dates.

[44] Specialist Smoking Cessation Clinic (April 2001 to March 2005) quit dates

7.3.9 Age

Age	% (n)
< 35 yrs old*	21.0 (221)
36 < 45 yrs old	33.6 (353)
46 < 60 yrs old	32.0 (336)
> 59 yrs old	13.4 (141)

The biggest proportion of the total number of quits were set by people aged 36 to 59.

Quit rates with the Specialist Clinic ranged from 64% in those under 35 to 71% in those aged 60 years and over.

7.3.10 Ethnicity

Ethnicity	% quit dates set (n)
White	75.5 (793)
Mixed	3.2 (34)
Asian	1.8 (19)
Black	15.1 (159)
Other	3.9 (41)
Not known	0.5 (5)

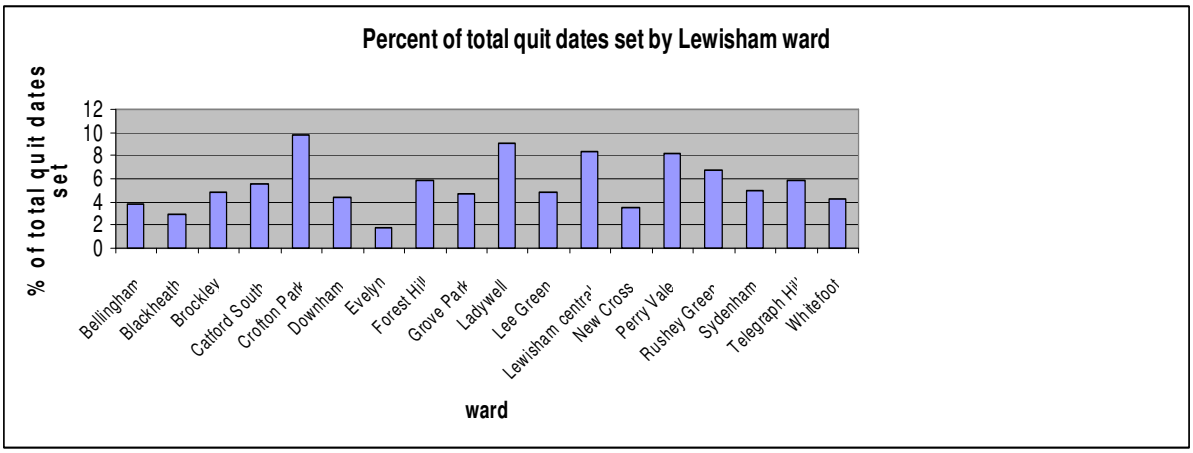
The highest number of quits were set by the White population, with 75% of the total. The next largest group was Black at 15%.

The quit rate varied from 74% among the Asian population to 63% in other ethnic group. The quit rate for the Black population was 69%, 68% for the mixed population and 66% for the White population.

Ethnicity	% quitting (number)
White	66.2 (525)
Mixed	67.6 (23)
Asian	73.7 (14)
Black	68.6 (109)
Other	63.4 (26)
Not known	60.0 (3)

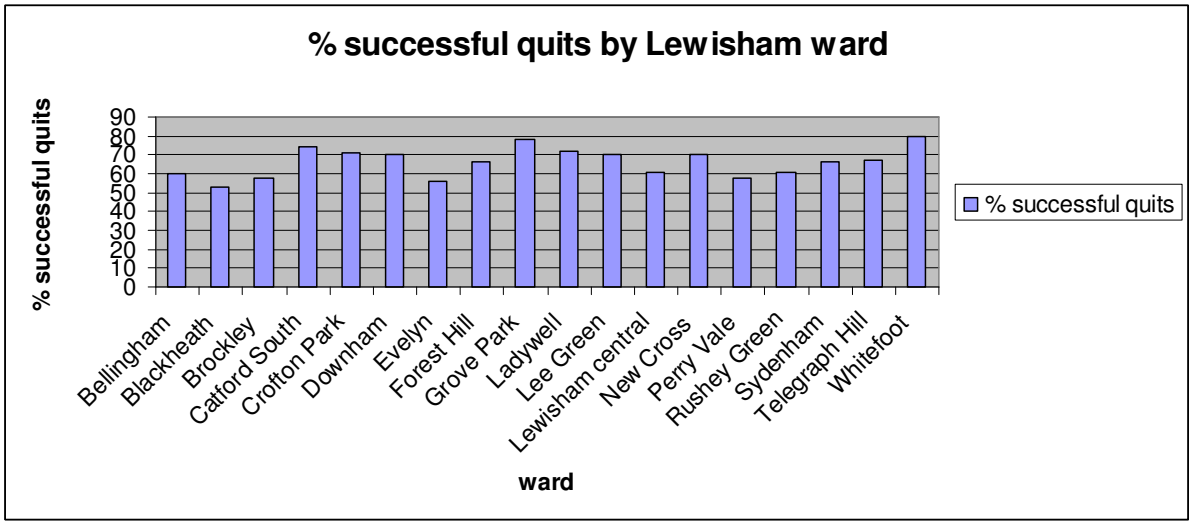
7.3.11 Ward differences

Perry Vale, Crofton Park, Ladywell and Lewisham Central wards had the highest number of quit dates set, with the lowest number of quit dates set from Evelyn, New Cross, Blackheath and Bellingham wards.



Ward	Percent of total quit dates set	% quitting
Bellingham	3.8	60
Blackheath	3.0	53
Brockley	4.8	58
Catford South	5.5	74
Crofton Park	9.8	71
Downham	4.4	70
Evelyn	1.7	56
Forest Hill	5.8	66
Grove Park	4.7	78
Ladywell	9.1	72
Lee Green	4.9	70
Lewisham Central	8.3	61
New Cross	3.5	70
Perry Vale	8.2	58
Rushey Green	6.8	61
Sydenham	5.0	66
Telegraph Hill	5.8	67
Whitefoot	4.2	80

The highest quit rates were to be found in Whitefoot (80%), Grove Park (78%) and Catford South (74%) and the lowest in Blackheath at 53%. Evelyn showed a low 56% successful quit rate.



Level 3 Service Summary

- **Between April 01 – Mar 05, there was a 67% success rate**
- **Slightly more females set quit dates than men**
- **Highest number of quit dates were set by the White population**
- **The Asian population had the highest quit success rate**
- **Evelyn, New Cross, Blackheath and Bellingham had the lowest number of quit dates set**

7.4 Feedback

The results of the 47 ex-service users surveyed are insightful in providing first hand feedback on their experiences of using a variety of Lewisham cessation services. Key insights from the surveys are as follows:

Positive comments

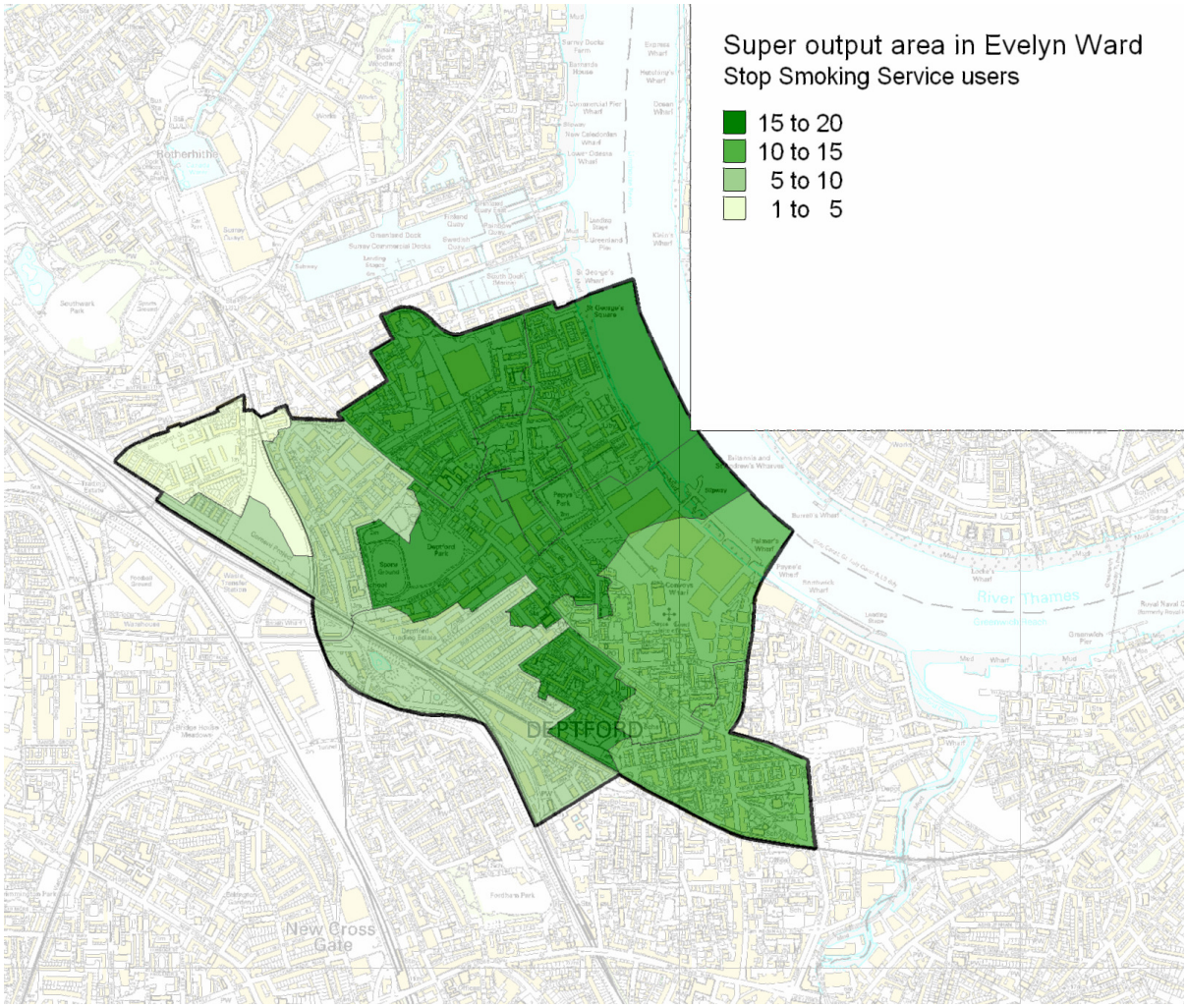
- Many people commented on the fact that they were able to save money on NRT products by accessing a cessation service
- Many people commented on their ability to access a wide variety of NRT options which was appealing as different methods work for different people
- The approachability and personability of the cessation advisor was vitally important

Negative comments

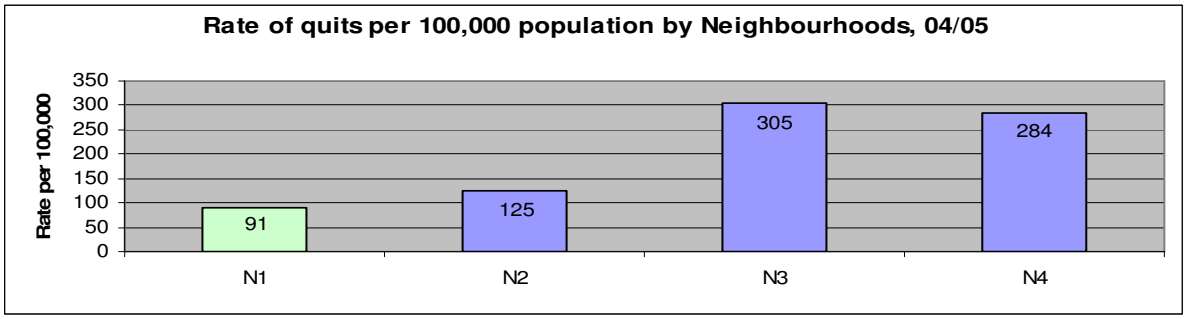
- Appointments were often hard to come by
- Cessation advisors (particularly nurses) seemed to be too busy to provide full attention to the client. Often there were queues of people waiting to see them for a variety of issues. It was felt that a dedicated cessation nurse should do nothing but help with cessation.
- Alternatives such as hyponosis and Allen Carr sessions were requested
- Better follow up from cessation advisors was requested

7.5 Smoking cessation services in Evelyn

There are a variety of smoking cessation services for Evelyn residents, accessed across the ward. The map below shows that the majority of smokers who access services live in the north of the ward:



The following graph illustrates that overall, N1 had a considerably lower quit success rate than the other neighbourhoods in 2004/5 (rate of quits per 100,000 population).



In 2006 (Jan to December) there were 166 smokers who accessed the smoking cessation services in Evelyn. 75 of these were successful quits (45%) and 91 unsuccessful. 99 smokers accessed cessation services via their GP. 44 accessed cessation services via a pharmacy:

GP	Quit dates set
Grove Medical	64
Amersham Vale	12
Kingfisher	12
Morden Hill	5
Dr Jamil (Waldrum)	1
Triangle	1
St John's	1
Mornington	1
Deptford Medical	1
Woodlands	1
Totals	**99**

Grove is clearly the most active surgery in terms of achieving quit attempts.

Pharmacy	Quit dates set
Lockyer	27
Pepys	6
Nightingale	5
Stromleys	3
Lewis grove	1
Hills Torri	1
Hills Sang	1
Total	**44**

Lockyer's pharmacy is clearly the most active pharmacy in terms of achieving quit attempts.

7.5.1 Performance of providers

2006/7: (This is a different time period to the figure of 166 quitters established for Jan – Dec 2006)

Total for the year - **270 quit dates set/ 97 quits (36%)**

Venue	Quit dates set	Successful quits	Percentage successes
GPs/clinics			
The Grove	42	16	38%
Kingfisher	12	Unknown	-
Waldrum	Dr Batra: 0 Dr Irvine: 68 Dr Jamil: 5	- 17 2	- 25% 40%
Clifton Rise	0 recorded	-	-
Mornington	24	6	25%
Walk in Centre	94	37	39%
Pharmacies			
Lockyer's	18	5	28%
Pepys	3	1	33%
Nightingale	4	1	25%

The Walk In Centre achieved the best quit results for this period (Dr Jamil's are too small in number to be counted).

2005/6:
Total for the year - **178 quit dates set / 79 quits (44%)**

Venue	Quit dates set	Successful quits	Percentage successes
GPs/clinics			
The Grove	72	30	42%
Kingfisher	2	2	100%
Waldrum	Dr Batra: 0 Dr Irvine: 16 Dr Jamil: 0	- 7 0 (no advisor)	- 44% -
Clifton Rise	0 recorded	-	-
Walk in Centre	34	14	42%
Pharmacies			
Lockyer's	18	5	28%
Pepys	19	19	100%
Nightingale	11	5	45%

Pepys Pharmacy appears to have achieved a 100% success rate, although this is highly unlikely and needs to be verified. Second to this, Nightingale Pharmacy achieved the highest success rate in this period.

Some information is available which breaks down these services by their results per quarter of 2005/6 and 2006/7. (This is not conclusive as much information is missing and many of the % values are invalid because of the small figures in question):

2005/6 data

VENUE	Cessation facilitator	Stats	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Mornington (GP)	Sandra Franklin	Attempts				
		Quits				
		%				
Grove (GP)	Valerie Pusey	Attempts		10	9	21
		Quits		0	3	13
		%		0%	33%	62%
Kingfisher (GP)	Joanne O'Dei	Attempts				2
		Quits				2
		%				100%
Waldrum: Dr Irvine	Tracy Carson	Attempts			2	
		Quits			2	
		%			100%	
Pepys Pharmacy	J Akther	Attempts			13	5
		Quits			4	4
		%			31%	80%
Lockyer's Pharmacy	Ian Schlazer	Attempts		8	3	10
		Quits		4	2	4

		%		50%	67%	40%
Nightingale	Gita Patel	Attempts			3	
		Quits			1	
		%			33%	
	Dr Salvanathan	Attempts				20
		Quits				20
		%				100%
Walk in Centre	Bernadette Kirby	Attempts			17	15
		Quits			7	9
		Non-quits			41%	60%
Positive Place	Colin O'Neil	Attempts		1		2
		Quits		0		2
		%		0%		100%
	Michael Knight	Attempts			2	
		Quits			2	
		%			100%	
	Bernadette Kirby	Attempts			2	
		Quits			0	
		%			0%	

2006/7 data

VENUE	Cessation facilitator	Stats	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Mornington (GP)	Sandra Franklin	Attempts			2	20
		Quits			1	5
		%			50%	25%
Grove (GP)	Valerie Pusey	Attempts	18		18	5
		Quits	6		6	4
		%	33%		33%	80%
	Ibijal shah	Attempts		12	16	
		Quits		7	5	
		%		58%	31%	
	Louise Philpot	Attempts			1	
		Quits			0	
		%			0%	
Kingfisher (GP)	Bing Khakwani	Attempts			2	
		Quits			0	
		%			0%	
Waldrum: Dr Irvine	Jackie O'Brian	Attempts				32
		Quits				8
		%				25%
Pepys Pharmacy	J Akther	Attempts	1			3
		Quits	0			1
		%	0%			33%
Lockyer's Pharmacy	Ian Schlazer	Attempts	3		9	5
		Quits	1		3	1

		%	33%		33%	20%
Nightingale	Gita Patel	Attempts				5
		Quits				1
		%				20%
Walk in Centre	Bernadette Kirby	Attempts	27	12	19	30
		Quits	13	6	8	10
		Non-quits	48%	50%	42%	33%
Positive Place	Colin O'Neil	Attempts				3
		Quits				0
		%				0%

Summary
These tables include flawed and incomplete data. The data available does suggest that:

- **The Walk In Centre had the most attempts and successes in 2006/7**
- **The Waldrum had many attempts in 2005/6 but far fewer in 2006/7.**
- **The Grove had many more attempts in 2006/7 than 2005/6**
- **Overall the GP practices had fewer attempts than the pharmacies.**

7.5.2 Training available

Level 2

There are currently 242 trained level 2 advisors but many of these are not 'active'. They come on training but do not then offer individual advice to smokers. Some leave their jobs; some say it is not possible to do this work within the constraints of their other work; some may attend because they are managers or supervising others who do this work. People who come on training are now asked why they do so. There is an expectation of their becoming level 2 advisors or being managers/ trainers of other staff.

There was 2 day training offered every 2 months in 2005/6. In 2006/7 1 day with half day follow up is being piloted. This is being offered quarterly in response to practices which cannot release people for 2 days in a block. This should equip people to offer one to one advice to quitters. People can observe an experienced advisor if they feel nervous about starting and there is onsite support on offer.

Level 1

There are currently 220 people trained at level 1 but this figure is expected to be an underestimate. Not everyone who has been trained has been recorded on the PCT's system. Also, we now offer this as part of induction for all new PCT staff.

The PCT's strategy for level 1 training is to train all front line health staff through induction or in teams. This includes

- practice nurses
- all staff in GP practices
- midwives

- district nurses
- health visitors
- hospital staff
- school nurses
- mental health teams
- lifestyle assistants
- intermediate care staff
- therapists
- chiropodists
- dental nurses
- youth service
- social care staff
- leisure staff
- voluntary and community sector staff.

It is also the plan to train ex-smokers or interested residents who want to be volunteers, private gym staff and beauticians/ hairdressers.

This is 2 hour training to give information, raise awareness, assess readiness to quit and signpost to service. They are given cards with our freephone number to hand to people.

There are update sessions for trained level 2 advisors

2 per year in the afternoon - practice nurses and community staff
2 per year at the evening pharmacy forum 7-9.30pm
1 a year evening practice nurse forum

There are 3 sessions of GP short courses - tailored for GPs.

Level 3 training

6 sessional staff are level 3 trained - this is a 3 day training for advisors/ co-ordinators to run group/ more intensive support to quitters.

QUIT training is planned for June 2007 for staff working with young people.

7.5.3 Further analysis

The purpose of the following section is to determine which segments of the Evelyn population are using which cessation service. We have established that smoking cessation trends, beliefs and practices vary by age, gender and ethnicity, so it is logical to presume that these segments in Evelyn are accessing the services in different ways.

7.5.4 Ethnicity

The following table suggests that by far the largest proportion of people accessing Evelyn smoking cessation services come from the White ethnic group (68%). Black African and Caribbean smokers follow this (14%) with Asian smokers having accessed the services the least (2%). There were no Chinese people accessing the service in 2006.

Ethnicity	**Quit dates set (2006)**	**% of quit attempts by**

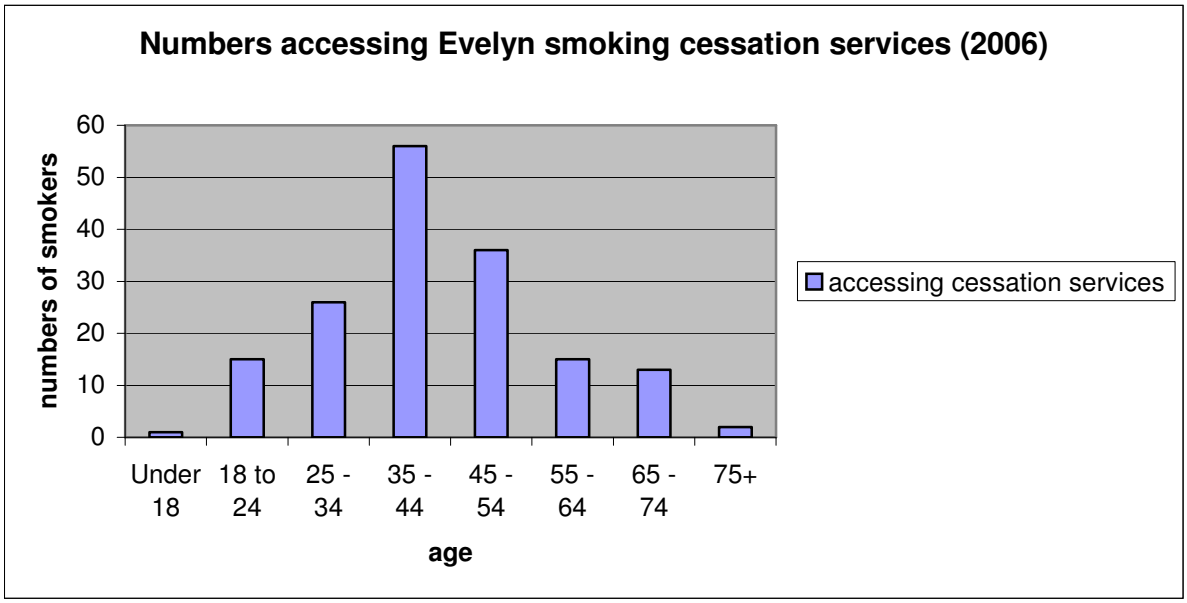
		ethnicity
White British	94	57
White Irish	4	2
Other white background	13	8
Mixed White & Black Caribbean	2	1
Mixed White & Asian	0	0
Other Mixed background	0	0
Indian	2	1
Pakistan	1	1
Bangladesh	0	0
Other Asian Background	0	0
Black Caribbean	12	7
Black African	11	7
Other Black Background	2	1
Chinese	0	0
Turkish	4	2
Any other Ethnic Group	7	4
Not Stated	12	6
Blank	2	1
Total	164	

Although with this data we have no idea whether certain cessation services are providing an appropriate service for the BME groups in Evelyn, the all round small numbers of BME smokers accessing any services at all strongly suggests that there is a gap between the services provided and the needs of BME smokers.

7.5.5 Gender

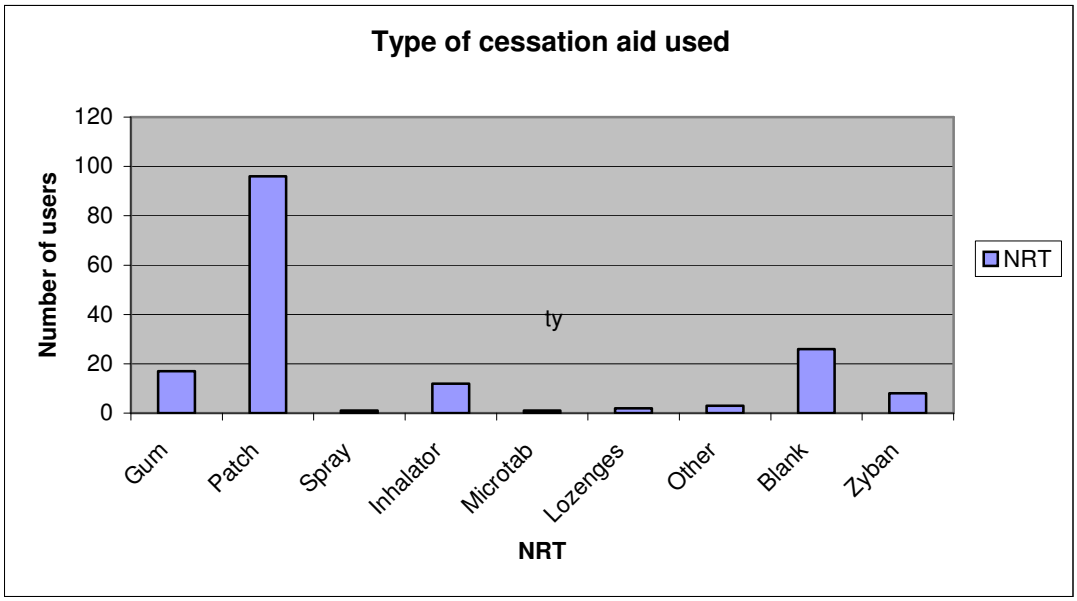
89 women accessed smoking cessation services in 2006 compared with 77 men. More men smoke than women in Evelyn, so this statistic also suggests that for an unknown reason men are not accessing the services as much as women.

7.5.6 Age



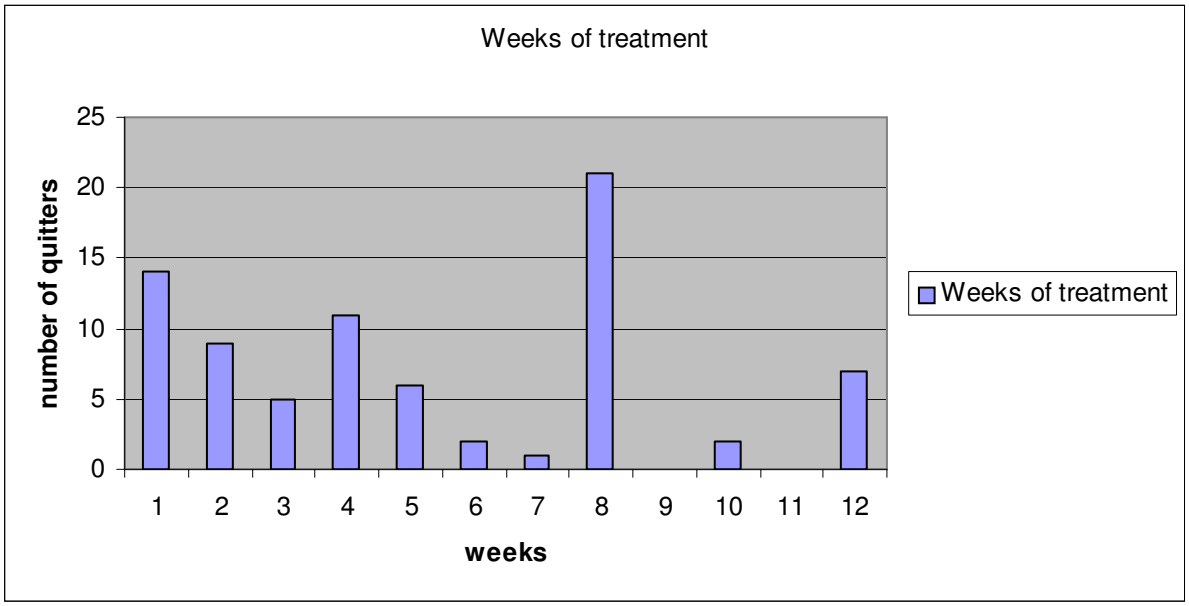
The chart above shows that the largest age group accessing smoking cessation services from Evelyn are the 35-44 year olds, followed by the 45-54 year olds and 25-34 year olds. It may be that services are unappealing to the younger and older areas of the spectrum.

7.5.7 Cessation aid preferences



The graph above shows that patches are the most popular form of cessation aid for Evelyn quitters. Gum is the second most popular and inhalers followed by Zyban the next most popular.

7.5.8 Weeks of treatment required



The graph above shows that the most popular number of weeks of treatment required by quitters in Evelyn was 8 in 2006, followed by 1 then 4. 88 people did not state how long they required treatment.

7.5.9 Pregnant smokers

There were no pregnant smokers seen by any smoking cessation service in 2006. This is unlikely to be because there were no pregnant women who smoked. Therefore there may be a gap in the service provision which does not meet the needs of smoking pregnant women.

Summary

- **No pregnant women from Evelyn were seen by smoking cessation advisors**
- **The cessation services are most popular with 35-44 year old Evelyn smokers**
- **More women than men from Evelyn accessed the services in 2006.**
- **More Evelyn residents from the White ethnic group accessed the services than any other, with Asian residents accessing the services the least in 2006.**

7.6 Recommendations for current service provision

Discussions with various stakeholders has thrown up a series of recommendations for changes or adjustments to current service provision:

- **Specific Waldrum smoking cessation clinic.**

  Dr Irvine commented that this is difficult because if people do not attend the advisor's time is wasted. However, it may be possible to implement a clinic across the 3 GP practices currently in the Waldron. Service users have commented that they feel rushed and not fully attended to when a long line of 'sicker' people are waiting to see the nurse advisor.

- **Employing a relationship marketing approach.**

Notes from Gerard Hasting's new book (unpublished

Relationship marketing means building relationships with potential, current and future customers in order to generate loyalty and repeat custom. In terms of smoking cessation services it would mean communicating regularly with smokers, service users and ex-service users (both successful and unsuccessful quitters).

Gerard Hastings (2007, unpublished) commented that "Of the 235,000 smokers who used the English SCS in 2003, 45% failed to quit at four weeks; the SCS recorded their failure and sent them on their way. But to have got that far they must be very committed to kicking the habit; half of those assessed and assigned to the SCS do not make it to the first appointment let alone the week 4 quit date. Surely it would make sense to hand these people on to a continuing service of some kind - maybe through links with the third sector as Wanless (2004) suggests? Putting them back to the standard SCS clearly is not appropriate; though at the moment that is effectively all the NHS offers them. At the very least they comprise a valuable list of promising potential quitters.

“The 55% who succeed are also sent on their way, with no support or help through the ensuing ten and a half months of struggle, after which they get a call to check to see if they have indeed succeeded. Most - three quarters of the 55% - will confess failure. Again they are deeply committed to quitting and nearly made it, but the SCS severs links. Not so much as a card of commiseration and a word of encouragement to keep trying - although we know that most smokers need several attempts before they quit successfully.

“If they are part of the chosen few, the 15% who have successfully quit, they will probably be asked to provide a saliva sample to verify that they have really quit - because the demands for rigorous outcome evaluation mean their word is not good enough. And then links are severed. And yet these are the Service’s greatest successes; their most loyal customers. They will be extremely pleased with themselves and – chances are - the SCS.”

Several advisors commented they do not have time for follow ups.

- **Non-practice based clinics**

8.0 There are clearly barriers for parts of the community in visiting a GP, so a clinic based at a community centre but run by practice nurses may have more success.

8.0 The behavioural problem

8.1 The presenting issue

- There is a high smoking rate in Evelyn of 42%
- There is a relatively low percentage of people wanting to give up
- Non-white ethic groups do not access current cessation services as much as the white population.
- More women set quit dates than men
- No pregnant women accessed cessation services in 06.

8.2 The possible target group

- The male smoking rate for Evelyn is 49%, much higher than for women.
- Women set far more quit dates than men
- Members of the BME population set far fewer quit dates than from the White population.

Further indication of possible segmentation strategies will be explored later.

8.3 Questions

This scoping report and subsequent primary research will seek to answer the following questions:

General

a. Why is there such a high smoking rate in Evelyn?
b. Why are there a relatively few people wanting to quit in Evelyn?
c. What social marketing interventions are likely to be able to improve the behavioural problem for the target group?

Ethnicity

d. How do the various ethnic groups view and use current services?
e. Are current services appropriate for all ethnic groups?
f. Why do more members of the White population access cessation services than other ethnic groups?

Gender

i. Why do more women set quit dates than men?
j. Why were there no services accessed by pregnant women?

The purpose of answering these questions is so that the intervention design can skilfully and knowledgeably focus on a relevant and valued exchange with the target group. If the social marketer can offer the target group something viable with which to exchange smoking (so 'you give up and we will give you x') then the intervention is most likely to succeed. It is only possible to define this exchange with rigorous client insight.

9.0 Behavioural influences

Social marketers must think carefully about what influences behaviour as a background to trying to change voluntary behaviour. Hastings (2007, unpublished) suggests behavioural influences can be broken down into 2 areas:

- First there is the relatively direct influence of friends, family and the local community, what has been termed the "immediate environment".
- Second there is the more indirect influence of social mores, economic conditions and cultural norms, which we have called the "wider social context".

More specifically, Steptoe and Wardle (2003)[45] consider the differences between the health behaviours of different socio-economic groups by looking at socio-economic differences in attitudes to health and ill health prevention. They state that:

> "The determinants of socioeconomic differences in health behaviours are poorly understood but are likely to include characteristics of the physical environment (for example, places to walk, availability of healthy foods), social norms (for example, smoking levels in the community, eating habits), and the costs of health protective behaviours. Individual knowledge, attitudinal, and motivational factors stemming from educational access, life experiences, and the general level of health consciousness expressed within the local social environment, are also relevant".

This section addresses possible environmental, psychological, social and cultural influences over the smoking behaviour of Evelyn residents by looking at clues from behavioural theory, the environment of Evelyn and the psychographics of Evelyn residents which may help provide preliminary insight into those factors which may influence the smoking prevalence of the ward. Where relevant, questions have been posed and preliminary answers sought from conversations with individuals working within the Evelyn community.

9.1 Pointers from behavioural theory

The third NSMC benchmark criteria for social marketing interventions and the social marketing approach is that theory be used as a basis of understanding and planning for behaviour change. Theories have been widely applied to behaviour change in the smoking arena. By way of introduction, a short summary of key relevant behaviour change theories will be described:

Theory	Description
Health Belief Model	Explains and predicts health behaviours using the attitudes and beliefs toward disease, especially perceived barriers, perceived benefits, and perceived susceptibility. The more susceptible an individual believes they are to ill health, the more motivation the theory predicts they will have to proactively preventing and treating ill health.

45 Wardle, J and Steptoe, A (2003). Socioeconomic differences in attitudes and beliefs about healthy lifestyles J Epidemiol Community Health; 57: p.440–443

Theory of Reasoned Action	Linearly links individual beliefs, attitudes, and intentions to action. Assumes that behaviours are under volitional control, and intention of quitting smoking is the most important indicator of behavioural change.
Theory of Planned Behaviour	Identical to the Theory of Reasoned Action but with an addition of a barrier, perceived behavioural control (PBC). PBC is an individual's belief that they can overcome barriers to achieve their goals (such as not having money or facilities or a supportive physical environment). Intention is still the most important predictor of action.
Elaboration Likelihood Model	Attitude change via the central route (individuals are highly motivated) is relatively permanent, resistant to counter-argument, and predictive of behaviour; the peripheral route (individuals are less motivated) is less permanent.
Stages of Change Theory	The five stages are precontemplation, contemplation, preparation for action, action, and maintenance. The route through the stages is no longer considered linear; rather a cyclical process that varies for each individual. The success of an individual's movement through the stages depends on their degree of perceived self-efficacy (PSE), how much belief they have that they will succeed. The further along the stages they move the more PSE they have.
The Health Locus of Control Model	Individuals have different types of perceived control over their health: a. **Internal control:** A person believes they have control over their current and future health through their own choices and behaviour. b. **External control:** A person believes that powerful others, such as doctors or family, have control over their health. c. **Chance control:** A person believes the state of their health is down to chance, such as genetics. With internal control, an individual is more likely to take proactive and preventative control over their own health.
Social Cognition Theory	Human behaviour is reciprocally determined by internal personal factors (such as knowledge and PSE) and environmental factors (such as levels of deprivation or availability of facilities in the local community) (Bandura 1986, Maibach & Cotton 1995). Environments shape people and their behaviours who in turn shape their environments through their behaviour and expectations
Exchange Theory	All social marketing is underpinned by Exchange Theory, and the concept of exchange forms the fifth NSMC benchmark criterion for social marketing. In order to increase consumer's readiness to change, therefore, social marketers must provide them with something beneficial in exchange

9.1.1 Social norms and salient beliefs

The Theories of Reasoned Action and Planned Behaviour suggest that social norms, and salient beliefs will inform an individual's attitude to a behaviour and therefore their intention to do it and ultimate behaviour change.

Crucially, smoking is a visible, public behaviour so the influences of key reference groups and social norms will be particularly influential. Eating, for example, is a far less public behaviour so will be less strongly influenced by wider social norms, although family influences will be strong.

a. Family

Smoking behaviour is undoubtedly influenced by family and friends; Family is one of the most important reference groups. If it is normal for parents to smoke in the home, it will be difficult to present the behaviour to the adolescent as being socially unacceptable or indeed dangerous. Turning this argument on its head, a 2001 study found that contrary to popular belief, adolescents who perceive that both parents would respond negatively and be upset by their smoking are less likely to smoke (Sargent and Dalton, 2001).[46] This suggests that family norms are strongly influential over an individual's attitude to smoking and therefore their intention and ultimate action.

b. Friends

Smoking also plays an important part in many adolescents friendship reference groups. Rose, Chassin, Presson and Sherman (1999) explain that adolescent cigarette use can be predicted from the influences both of best friends and friendship groups. These influences include peer smoking, peers' tolerance of smoking, and approval of smoking among best friends. Furthermore, other researchers have found that a lack of disapproval for smoking on the part of the peer group is related to a greater likelihood of smoking among adolescents. Both close friendships and wider friendship groups can provide opportunities to smoke as well as reinforcement for smoking. As a result of the importance of these peer factors, prevention programs have made resistance to peer influences a major focus, and such programs have had some shortterm success."

Friends are so influential a reference group to adolescents because of their particular developmental stage. In the search for a firm identity, friends and belonging to a peer group becomes emphasized in symbolic importance. Therefore artifacts which symbolically link the individual to a particular group, and by association disassociate them from others, also have emphasized importance. Smoking often becomes one of these symbolic linkages.

Smoking also appeals to adolescents because it is considered to be 'grown up' and can appear to them to accelerate the maturing process. Highlighted in the smoking ban section was the issue that if smoking is not considered to be socially normal to adults, it may no longer have the appeal to adolescents as being immediately associated with 'being an adult'.

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[46] Sargent, JD and Dalton, M, (December 2001). Does parental disapproval of smoking prevent adolescents from becoming established smokers? PEDIATRICS Vol. 108 No. 6, pp. 1256-1262.

c. Social norms

Social norms relate to community wide perceptions about acceptable behaviour, as distinct from the more direct (and important) influence of family and friends. A recent study by Wakefield and Forster (2005)[47] found that youth living in towns with smoke-free restaurant laws that completely banned smoking had lower rates of progression to smoking than those youth living in towns with weaker or no laws.

Wakefield and Forster found that it is possible to change social norms through policy change (not allowing smoking in public):

> Limiting where individuals may smoke in the community substantially changes social norms for tobacco use… Breaking the nexus between freedom to smoke and adulthood may counter the normative association of smoking as an acceptable adult behaviour.

The implication of this is that visible social norms, such as a high prevalence of smoking behaviour like Evelyn, leads to higher smoking uptake rates because the social norm is to smoke and this influences behaviour.

The influence of this social norm works on 2 levels. Firstly, there may be a conscious decision to take up smoking in order to be part of the community in which you aspire to fit in or live:

> Individuals use products and brands as materials with which to cultivate and preserve their identities.
> (Piacentini and Miller, 2004)

This explains in part why many teenagers start to smoke, to fit in with a group they aspire to be part of.

Secondly, less conscious influences are at work. Most people subconsciously act in order to comply to social norms because to not to do so would be social embarrassment. We subconsciously copy those around us in order to blend in by wearing a similar formality of dress, using similar language and even complying to rules about personal space and methods of greeting. If an individual's society clearly and visibly endorses smoking then that norm will likely to complied with.

The Social Norms marketing approach uses the influence of social norms for behaviour change. This approach gathers credible data from a target population before consistently telling it the truth about its actual norms, via a number of marketing strategies. The aim is that with repeated exposure to a variety of positive, data-based messages, the misperceptions that help to sustain problem behaviour are reduced, and a greater proportion of the population begins to act in accordance with the more accurately perceived norms of positive behaviour.

This approach is based on the fact that members of a social group are influenced by their perceptions of social norms, even if their perceptions are ill-informed. Within the context of student alcohol consumption for example, if the population believes that most students drink heavily, then this misperception is reflected in a higher rate of problem drinking. If students believe that drinking heavily constitutes normative behaviour, there is a greater likelihood that they too will drink more heavily, while at

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[47] Wakefield, M and Forster, J; (2005). Growing evidence for new benefit of clean indoor air laws: reduced adolescent smoking. *Tobacco Control.* **14**:292-293; doi:10.1136/tc.

the same time believing that protective behaviours and moderation ore uncommon. If the number of students who overestimate heavier drinking as normative behaviour is reduced, then there will be a corresponding reduction in actual heavier drinking.

In the context of smoking in Evelyn, this approach is questionable given the undeniably high numbers of very visible smokers. This discussion has shown that the overwhelming social acceptability of smoking within this community is detrimental to any marketing intervention.

9.1.2 Subculture

Culture is powerful and largely unacknowledged by those living within it. An early definition of culture which went beyond the concept of it as simply 'high culture' denoting civilisation and superiority was by Tylor (1920). He expanded the notion to encompass "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society"

Culture is thought to be passed on (through a process called socialisation) through schools and other public institutions and is eventually internalised so that conformity becomes a matter of individual will (Durkheim, 1956 [1925]). Parsons (1955) treated socialization through the family as the main mechanism for internalizing and reproducing society's common culture. Freud (1930) believed that culture also incorporates an instinctual knowledge of the cultural prohibitions and renunciations that have been accumulated over the ages.

Durkheim wrote about an overarching culture across societies known as the "collective conscience". He described this as a representation of all that was common in society. It stood above the individuals in society as a fact and constituted a set of organizing principles on the basis of it"[48].

It could be considered that beneath this collective conscious stand numerous subcultures of organisations, institutions, professions, geographical regions, ethnicities and classes. It can be considered that the social norms of a particular society are both generated by and reaffirm a subculture.

To put this theory in context, it is suggested that in Evelyn, there are subcultural forces at play from a combination of the region (South East, London, Lewisham), ethnic make up and also as a result of the deprivation and working class background.

Smoking is known to be strongly linked to socio-economic deprivation but it is suggested here that the prevalence of smoking may also be linked to cultural norms which have developed as a result of the social norms we have discussed. The Health Development Agency's study "Perceptions of smoking cessation products and services among low income smokers"[49] found that "Smoking was accepted within these communities, and smoking levels were said to be high among families

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[48] Munch, Richard, and Neil J. Smelser, editors *Theory of Culture.* Berkeley: University of California Press, c1992 1992. http://ark.cdlib.org/ark:/13030/ft8q2nb667

[49] Jackson, N; Prebble, A and Conway Smith, R (2002). Perceptions of smoking cessation Products and services among low income smokers. *Health Development Agency Report* [online, accessed June 2007].

and within friendship groups. Many started smoking regularly in their early teens, and most were surprised at their parents' willingness to accommodate their smoking (either actively or passively)".

The report also states that "social interaction and inclusion (smoking was ingrained in social life, although the opportunities for social interaction were often few and far between, especially for unemployed people and lone parents)". Also, the report found that one of the things that decreased smoking heaviness (of a list which included ill health, pregnancy, smoke free workplaces or social venues and disposable income) was visits to friends' houses where the occupant did not smoke or allow smoking indoors. This statement is qualified in the report by saying that most interviewees did not know anyone who met this description. Respondents were even aware that, within society, smokers were increasingly perceived as social pariahs. However, "they also believed that smoking was the norm within their community." It could be said that smoking is part of working class culture in Evelyn and is not just a function of limited education or other socio-economic factors.

A possible repercussion of smoking having become a subcultural norm is the issue of image incongruency. If smoking is strongly associated with working class life and disassociated with alternative lives (such as middle class life), there is a strong possibility that the image of a non-smoker may have become significantly incongruous with the self image of working class individuals in Evelyn. The Health Development Agency's reearch into the perceptions of low income smokers found that "Non-smoking was widely associated with people who had done better at school, obtained gainful employment and moved away from the area". If not smoking is associated with people who are not living in the area, then it may be difficult for smokers still in the area to associate with their image of a non-smoker.

This image incongruity itself can therefore become a barrier preventing a working class pre-contemplator or contemplator from quitting. Indeed, the Health Development Agency further found that in their research "Overall, there seemed to be no culture of quitting within these communities. Few could ever see themselves as nonsmokers. Several had no intention of giving up". As the discussion of working class social capital will show, the added complication of closed off, often insular communities can make this image incongruency even more heightened. Another way of looking at it is that visibility of alternatives is difficult.

Possible reasons why smoking is integral to working class culture:

- Traditionally, office and public-facing work associated with non-manual occupations may have been more likely to involve a 9 -5 structure of not-smoking. Building, scaffolding, painting and other manual work involved no such restrictions.
- Working class leisure is traditionally non-physical. After a physically demanding day doing a manual job, leisure time is often spent at the pub, betting shop, races or watching football. Indeed, Hillsdon and Fox (2007)[50] recently commented that "participation rates [in physical activity] are lowest in disadvantaged groups such as those in lower socioeconomic groups and ethnic minorities". These activities often encourage smoking. Middle class

[50] Fox, KR and Hillsdon, M, Physical activity and Obesity 2007) *Obesity Reviews* 8, Suppl.1, pp. 115-121.

leisure activities are often more active, such as sports, walking, sailing, gym, badminton or squash clubs. The drink after these activities may involve smoking but the activities themselves do not.

The hard nature of manual labour and the historical legacy of a 'them and us' attitude towards the middle class industrial managers and owners has traditionally been considered to have forged a strong culture of unity amongst working class individuals:

> "group solidarity is cemented by a common experience of adversity and opposition to mainstream society" (Portes, 1998).

This is emphasised by the close social structures of many lower income communities. Socialising amongst individuals similar to each other, then, both promotes smoking as a social pastime and also emphasises the norm of smoking through limited mixing with people with alternative social norms.

To conclude, the culture of class should not be overlooked by social marketers wishing to market behaviour change. It is likely that smoking is an integral facet of working class culture, established over time as an important symbolic accompaniment to working class social working and leisure activities.

9.1.3 Social Capital

At this point it is also useful to introduce the concept of social capital as it will inform the discussion on behavioural influences for the target group. Social capital refers to the "networks that link individuals and the resources embedded in those linkages" (Kraig and Hipp, 2005). Put simply, social capital refers to the potential personal gain to be had from a connection with an individual. This could be tangible like a financial or business gain, or intangible such as a status gain.

Someone with a large and diverse social network is likely to have a great deal of social capital. A well connected businessman, for example, will be able to call in favours from contacts and the contacts of contacts. By contrast, someone with a small and analogous social network can be said to have limited social capital. Crucially, as Cattell (2001) explains, "networks can provide social support, self-esteem, identity and perceptions of control.

a. Working class social capital

Often, working class families will settle in the same small geographical area in cascading generations. By contrast, university education is an automatic dispersal mechanism for middle class families, graduates often choosing to work and settle in their university cities, often far from their family home. Working class social networks, and consequently their social capital, are consequently considerably more limited than middle class social networks. This may be largely due to a lack of income, which limits housing choice to council housing estates, but cultural preferences may also be influential. Put in sociological terms, working class people will likely have less 'bridging' social capital.

Although the working class group have far smaller and less diverse social networks, the social bonds which tie community members together, known as bonding social capital, can be extremely strong. In deprived communities, the key social network is with family, who often live very close estates. Bonding social capital can often be far

stronger in closely tied, less mobile working class communities than in diverse, fluid and often lonelier middle class communities.

c. Implications of working class social capital

The positive benefits of social capital are well documented as Kraig and Hipp (2005) explain:

> Social capital promotes social support, boosts physical health, improves academic performance and increases job contacts.

Middle class individuals, with large and varied social networks (considerable bridging social capital) and financial backing, are often able to pursue a far greater number of different opportunities, hobbies, activities, holidays, sports, clubs and interests than working class people. The result of diverse and numerous opportunities is a broad horizon which in turn places middle class groups in contact with a diverse and extended group of people (and more social capital).

People with less social capital will be presented with fewer fresh opportunities and therefore fewer chances to increase and diversify their social capital. Limited social capital causes a spiral of restricted opportunity.

The result of increased opportunity and experience is confidence and experience of success. This leads to self-esteem, self-sufficiency and perceived self-efficacy, a facet of the Transtheoretical Model which is considered critical for behaviour change. Here, we remember Cattell's statement (2001) that "networks can provide social support, self-esteem, identity and perceptions of control". Perceived self-efficacy and locus of control will be discussed further in the next section, but it is valuable her e to quote Cattell again, who pinpoints a link between low social capital and health: In her housing estate of focus, "Those with the more restricted networks… tended to feel anxious, depressed, suffered from headaches and stomach complaints, as well as a variety of other physical complaints". This link can be unraveled further, but at this stage it is satisfactory to have made the surface association between limited social capital and ill-health or at least inability to take control of health or ill-health.

In addition, the implications to strong bonding social capital should be considered. Strong bonding social capital can be seen as a positive influence in communities due to the social support and care given by members to their neighbours and friends. It can also, however, be considered a negative influence if the ties are so strong as to seal off the community from outside influence altogether. Putnam suggested that "if there is only bonding social capital it can result in hermetically sealed communities, like in Belfast or Bosnia." This type of social capital has been considered to be negative, the results of which are

- Exclusion of outsiders
- Excess claims on group members
- Restrictions on individual freedoms
- Downward levelling norms (Portes, 1998).

Put simply, bonding social capital can strengthen the social norms and salient beliefs already pivotal in the culture. If the culturally pivotal norms include smoking, the bonding social capital closing off a community can strengthen the norm to smoke.

Potentially a contributory factor, it is of note that there are no train or underground links to Evelyn and only 6 bus routes that go through the ward or on the border. New Cross or Deptford railway stations are the closest. However, as the ward profile tells us, "There is a heavy reliance on public transport as a means to get to work in this ward, with the tube in particular becoming an important means of transportation despite there being no underground station in the ward.

The following table indicates car ownership levels and shows that more than the Lewisham average do not own a car. Less people across London own cars but this is most likely due to the availability of the underground system.

Proportion of households with:	No car	One car	Two cars	Three or more cars
Ward	54.1%	38.7%	6.4%	0.8%
Lewisham	iii. 42.8%	43.4%	11.6%	2.1%
London	37.5%	43.1%	15.8%	3.7%

Cars per 100 population	Ward	Lewisham	London	Rank in borough
	54.0	73.8	86.7	17th

The lack of car ownership and poor public transport links may contribute to the insular nature of the ward and the lack of availability of outside leisure facilities for socialising and improving social capital[51]. Although not far from central London, the ward feels isolated and, as Lewis Herlitz of the Pepys Community Forum commented, many residents act as though it were totally insular.

It is important to recognise, however, that different working class communities may have different degrees of bonding social capital, therefore leading to either positive or negative influences over health. Cattell (2001) describes 2 London estates with contrasting degrees of bonding social capital. The Keir Hardie estate is "a traditional working class neighbourhood, where residents have strong community loyalties, a strong sense of place, and a shared sense of history". Here, community is tied to the old dock work, which although ceased to provide employment a while ago, still forms the focal point for socializing for many ex employees. By contrast, the Cathall estate has a much criticized "alienating housing design, anti-social behaviour, and high population turnover" which has made it "difficult to develop and sustain local social networks, and undermines any sense of community". This suggests that it is important to assess the type of social capital present in the Evelyn estate.

d. Implications for social marketing

To influence social marketing intervention planning, it is logical to question what is known to increase social capital in working class neighbourhood. Cattell (2001) tells us that social and employment history, a community's services, facilities, housing, opportunities for casual meeting and for participation in associations, as well as the area's reputation, have all been found to play a role in improving social capital. Facilities within an area such as shopping centers, markets or the post office where casual meetings with (neighbours and those from further afield) can occur are essential for fostering casual weak ties and increasing the diversity of ties. In

[51] Evelyn, a ward profile: Summary of information.

addition, a housing arrangement where accommodation is designed to facilitate communication amongst neighbours and with safe and well-lit, pleasant communal areas where they can meet, chat and form friendships is crucial for encouraging the close homogenous ties of bonding social capital (Cattell, 2001).

Cattell (2001) found the effect of community groups important in increasing social capital. She acknowledged that the social capital produced by self interested groups can frequently be limited to that group, yet on one of the estates she studied (Cathall), bridging ties, seen as essential for generating wider social trust (Putnam, 1995), were being developed. An active resident reported: ''They [different associations] used to all keep themselves to themselves, but there's been a lot of groundwork done to bring the groups together. The Summer Festival, for example, had a really good feel about it''. (Cattell, 2001).

Cattell (2001) does admit, however, that despite the headway made by some community organisations in her researched communities, the majority of residents on both estates would not join activities and organisations. "Constraints include poverty, attendant feelings of defeatism, and the neighbourhood's reputation".
It is important, then, to establish not only the community organization that are at work in Evelyn and if there are any gaps which could be filled by voluntary sector activity but also the perception by Evelyn residents of the current community groups. The intervention review should also include any social marketing interventions which have attempted specifically to increase social capital for the indirect benefit of health. This may be an entirely upstream marketing activity, targeting government and local policy on housing, estate facilities and layout and also the mix of individuals housed together in social housing communities. However, Cattell's (2001) comment that her research findings suggest "that reputation [of an area] needs to be considered when exploring area effects. The origins of a neighbourhood's image are multifarious, and images influence the creation of networks and social capital". It may be possible, then to use social marketing to improve the reputation of an area in order to encourage network creation".

e. Questions: What type of social capital is evident in Evelyn?

a. **Are neighbours close or live in fear?**
b. **How long have people lived in the area?**
c. **What is the degree of intergenerational integration?**
d. **What is the residents' perception and opinion of life in the area?**
e. **What community organisations are up and running in the area?**
f. **What are local residents' perceptions of the community groups available to them?**

f. Answers

i. **Interviewee:** Lewis Herlitz, Pepys Community Forum
Lewis@pepyscommunityforum.org.uk, 02086943504

In your opinion, what is life like in Evelyn?[52]

Smoking is almost recreational for people in Evelyn. There was an LBC radio interview with someone recently during a programme in which they were talking about health. The woman being interviewed was asked what she did in her spare time and she said "I smoke". She listed her illnesses and claimed she smokes for something to do.

There has been considerable change in the physical environment of Evelyn. There has been regeneration in the buildings and people have been living in a state of perpetual uncertainty. Some have moved around and some new people have moved in. One tower block was sold off and other flats have been knocked down. It's trickle-fed change and will continue for 15 years.

The community infrastructure is volatile. There was an employment resource center but it lost its funding and has gone, although the building is still there and we're trying to get funding again. The youth club is successful at attracting BME young people but there are concerns about the fact that not many white young people are using the club. Noone knows why.

The community center has had its funding reduced and there has been an Arts Project here for 20 years but it has had reduced funding in the last 4-5 years. There is a general sense that there is little money put back into the community from the council's land sales. Lewisham Council do not seem to have a strategic plan for the future for Evelyn. People feel they have been short-changed by the council.

The area is diverse ethnically and largely harmonious. BME groups book the community center for parties but no white groups. There aren't a lot of social activities which bring people together.

There are a lot of young people in Evelyn. I think 50% are 24 or under. There is a bit of gang influence, although that is recent. There isn't enough for them to do. Antisocial behaviour isn't a massive problem and the police don't consider Evelyn a crime hotspot but there is certainly underinvestment.

People don't live in fear of each other but there is no talking. Some young mums I recently spoke to said the first time they have spoken to other young mums was at Sure Start.

There isn't really continuous population movement.

Lewisham is a large exporter of labour.

In the North part there is a diverse population. Some is deprived but it is more diverse than that. There are professional people living here too. There are people wanting to be self-employed. It is not a stagnant community. There is not much graffiti or rubbish. There is some but not much.

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[52] Answers have been paraphrased not transcribed.

Most people comment on the scrap yard. People think it is depressing. It worries people. They want it removed.

People seem to be disempowered living in council housing and not so much so in private housing. In council housing people have less choice. In the Pepys Estate there are 3 tower blocks. 1 was sold off and converted for private sale. A simple change was made which made a huge difference. They painted the walls cream and put in loads of soft lighting in the corridors and stairways. It feels bright and soft now. The council tower block is painted green and is poorly lit. Little things like that can make a huge difference. Also the areas where the bins are could be made to look better.

People feel that they can't influence what's around them so they need coping strategies.

What are your suggestions for improving smoking cessation in Evelyn?
You have to think about what would need to be different about the way people feel for them to be happy being a non-smoker.

We have done some one-to-one mentoring projects at the Community Project and I think there needs to be more like this. I feel like it's the tip of the ice berg. No-one seems to give up the time to follow this through. We need to focus on their 'inner world'. That's the key. People can be contented living with less money. Money isn't the answer.

ii. **Interviewee:** Alfred Banya, Community Development Coordinator
Alfred.Banya@lewishampct.nhs.uk, 020 7206 3272

In your opinion, what is life like in Evelyn?
Deprivation is a factor and Evelyn has the highest rates of unemployment in the Borough.

There is a large refugee community. Vietnamese refugees started arriving in the late 70s and are now settled. There are intergenerational difficulties between older Vietnamese and the second generation Vietnamese young people. They have difficulty relating to each other.

Also there are Somali refugees and asylum seekers. Again there are intergenerational issues and some drug taking and knife and gun violence.

The indigenous population are white and working class. Racial tensions are not a major problem. There are more internal tensions within each group than between them.

Many people are employed in the hotel and catering industries.

There are a few pubs on Evelyn Street and Deptford High Street. There is a leisure centre called Wavelengths in Deptford and The Albany Arts Centre which shows contemporary films. That is also in Deptford.

iii. **Interviewee:** Gayle Wallace, Neighbourhood Coordinator
Gayle.Wallace@lewisham.gov.uk, 07725-785717

In your opinion, what is life like in Evelyn?
Evelyn is a spread out ward. Historically it has a high density housing landscape. This has changed a bit in the last ten years but it is still predominantly high density. A few of the old tower blocks have been knocked down and replaced with normal houses but there are a lot of tower blocks and maisonettes still there. There are 6 housing associations in the area.

There is a high turnover of people in Evelyn. It's the area people least want to go to and they always want to move out. There is a transient population there. Some spots like Pepys have a more established community.

There are lots of agencies and organisations in Evelyn but my experience is that they don't work together. There are politics involved. The people who claim they are speaking for the community aren't necessarily and don't represent the community. The existing networks aren't necessarily representative. The point of the Neighbourhood Panel is to get existing organisations together to impact on their own targets.

Summary of interviews
- **There is considerable deprivation in Evelyn**
- **Refugee population has intergenerational issues**
- **People feel disempowered due to poor education, low incomes and poor, overcrowded housing**
- **Little social interaction but people do not live in fear**
- **Transient population with little community focus in parts**
- **Little evidence of inter-racial problems**

g. Community organisations available to Pepys Estate Residents

Pepys Estate is one estate in Evelyn with approximately 6500 residents. The Pepys Community Forum (PCF) funds, manages and tracks community initiatives. The following assessment of current community organisations provides an overall picture of the potential social capital structure within the estate. The overall finding is that there are community organisation available in the Pepys Estate area which target the most vulnerable groups. Number of attendees are quite low, however, and some of the iniatives are still seeking funding before they can become fully operational:

Line Dancing
The one existing group for the elderly, Good Retirements, has been accessing weekly gentle exercise line dancing classes for the last 15 months. Originally this was funded directly by the Silwood SRB but that is no longer available. PCF has now funded it for 28 weeks at a cost of £60 per week. Line dancing is regularly attended by 9 residents. Good Retirements are also concerned that there is currently no referral mechanism to their group from local health practitioners.

Healthy Living Group
This is a resident initiated and led group that began over 3 years ago, originally supported by PCF and now supported through the local Community Centre. The

original aspiration was that the group would be underpinned by their weekly aerobic exercise classes but that they would offer more 'services'. This has never happened so its just a mixed age/sex weekly exercise group that funds itself just for that at cost of £35 per week, average attendance per class is 12.

Food and Nutrition

There are various activities under way led by or in partnership with PCF through the South East London Development Agency:

Community garden/allotment:
The aim is to set up a totally edible community garden for social and educational use. Excess produce would be used to support some of the projects below. Co-ordinated by a local volunteer. Confirmation of funding is awaited.

Food Co-operative:
Co-op members order fresh vegetables delivered by an Orpington Farm. Advice and recipe ideas are promoted.

Community Cafe:
A partnership additionally involving the local community centre. The aspiration is to create a social hub and a place where fresh multi-cultural food is available. Being run by a local steering group of workers and residents. Some kick-start funding [£5k] available from PCF.

5 A day:
Involvement with this national project through local schools to encourage children and their families to move towards healthier eating. Part time paid co-ordinator funded by the New Opportunities Fund.

Me & Mine

A new, resident-led project, to provide a 1 stop shop approach to provide services, support and information for local people around mental well-being e.g. counselling, mentoring and life-coaching. There is a working party from different agencies and organisations. Community Education Lewisham has begun to offer life-coaching services. The resident who has spearheaded this is Sue Elliot who chairs the local Gingerbread group and is a qualified counsellor. She and PCF are looking for both space from which to run the project and funds both for that space, and to allow counselling/mentoring services to begin. The project currently has no funds.

Common Ground

This project deals with requirements and issues around all the local green spaces and general environment. Specific 'health' issues are:

- An opportunity to plant an 'orchard' in the central area so that residents can pick fruit
- The need to persuade developers to consider having fruit trees and herbs as part of their planting policy
- The tidying up of rubbish bin areas
- The creation of ramp entrances to a number of blocks where there are only stairs down to an entrance
- The creation of a small fitness centre

Health Development Worker
PCF has been attempting to pursue a discussion for the last few years about having a community based resource who could not only provide support to local health related initiatives, but could draw in resources and help the community make the right contacts to gain resources and support.

Music Creation for the Disabled
An opportunity to support a local resident developing an enterprise to provide music creation experiences for disabled people. Nana Owusu already runs some sessions at the Albany for people with learning disabilities but requires further training and equipment to top up what he already has. This is a specialist field and may be of real value to any agencies dealing with disabled people who would benefit from the stimulation and pleasure of 'creating music'.

h. Pepys Café Feasibility Study comments

Finally, it is noted that despite these community organisations available, there were comments made in the 2001 PCF report 'Pepys Café Feasability Study' that the Pepys estate required a community focus to provide social ties for disengaged members of the community. The report states:

"It was a commonly held belief that the estate required a central focus, or a 'hub' for community activity. It was felt that a café could provide this. This theme was felt to be especially important given that Pepys has a transient and diverse population, and is going through great structural changes in terms of housing developments. It was therefore proposed that the café could provide important visible signs of on going commitment to the community, and involvement of the community, at this time of great change.

"Some staff were skeptical as to whether the café would act as a point of engagement, although there was general consensus that ways of increasing and widening participation were a priority for practice on the Estate".

i. Conclusion

The type of social capital present in Evelyn is unclear. It appears that there is a combination of disengaged, isolated residents who have little intergenerational or interracial communication and also residents who make the most of the various groups and clubs available. There may well be a danger that the same small percentage of residents is involved in the community organisations. It is telling that the Pepys Café report concluded that the estate (although a small part of Evelyn) required a central focus to widen community involvement and participation. Overall it is likely that residents of Evelyn have limited social capital and the social ties they do have are likely to be very similar, with little opportunity for developing ties with people with alternative life paths.

9.2 Assets required to overcome cultural norms

It has been established that social and cultural norms support smoking and this in itself forms a barrier to cessation, possibly impacted by the nature of the social capital within the social networks of Evelyn. However, clearly some working class

people do quit and others never smoke. Evelyn may have an extremely high smoking rate but half the men and over half the women do not smoke.

Using terminology from the Stages of Change within the Transtheoretical Model, it is logical, therefore, to question what would be required for a working class pre-contemplator or contemplator to overcome these barriers and move towards the preparation or action stages. Put more simply, it is logical to question what is required for someone who has never considered quitting to move to a position where they are considering it and preparing to stop.

Commentators would argue that 'what is required' takes two levels, which can broadly be referred to in terms of societal and personal liability. This is strongly linked to the concept of upstream and downstream social marketing, already discussed.

To put these concepts into context, it could be considered that the responsibility of Evelyn's smoking prevalence is that of society, policy and government and that individual behaviour is directly influenced by decisions made upstream. If this is the case, resources should be focused on creating an environment in which smoking is not encouraged or supported. The smoking ban, for example, is one way that society will be acting to combat the smoking norm in parts of society and provide individuals with an environment which can ultimately change social norms and decrease smoking prevalence. We refer again to Wakefield and Forster (2005)[53] whose experience in the US is of a lower smoking uptake rate amongst youth in towns laws that completely banned smoking in public.

Another way of putting this in context would be to refer again to the interview with Lewis Herlitz who commented that the physical environment of the council-run tower block seemed to disempower tenants. Improving this, he suggested, may lead to an improvement in self-efficacy.

That said, few marketers, health workers or commentators would claim that society has the only and ultimate responsibility over individual health behaviours. Individuals must also take responsibility themselves. In Lewis Herlitz's words this is the 'inner world' of smokers. However, as has been discussed, the strong cultural and social norms clearly create environments in which both the desire to quit may be limited and the ability to quit unsupported. It might be said that currently the cultural environments in communities such as Evelyn are unsupportive of smoking cessation. To overcome this unsupportive cultural and social environment, behavioural theories suggest that certain psychological assets are required. The discussion here will describe three psychological assets; perceived self-efficacy, locus of control and long-term time orientation and put these assets in the context of smoking cessation.

9.2.1 Perceived self-efficacy

The Transtheoretical and Social Cognition Theories introduce the concept of perceived self-efficacy. PSE is "the belief that one can change risky health

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[53] Wakefield, M and Forster, J; (2005). Growing evidence for new benefit of clean indoor air laws: reduced adolescent smoking. *Tobacco Control.* **14**:292-293; doi:10.1136/tc.

behaviours by personal action" (Schwarzer and Fuchs, 1995), and is similar to motivation, drive and self-belief. According to the behavioural theories, perceived self-efficacy is essential for behaviour change, particularly when the behaviours are

a) Difficult. Smoking cessation requires will power and considerable effort and commitment
b) Contrary to social norms. With limited social support, personal drive is essential
c) Contrary to cultural norms. With limited tacit knowledge of the behaviour being adopted, self-motivation and often reliance on external help is required.

Given the prevalence of smoking in Evelyn and the likely low levels of social capital in the community, it is suggested that low perceived self-efficacy is a characteristic of the target group in general rather than individual members who have failed to quit. This is backed up by Lewis Herlitz of the Pepys Community Forum who suggested that "You have to ask why people smoke and I think it is because people see it as calming and providing confidence. Why do people need that? There is poor literacy and numeracy in Evelyn and lots of people are on incapacity benefit". Lewis is suggesting that the poor numeracy and literacy and unemployment leads to low self-esteem which contributes to low perceived self-efficacy. His later comment adds to this: "People seem to be disempowered living in council housing and not so much so in private housing. People feel that they can't influence what's around them so they need coping strategies".

Indeed Roddy *et al,* (2006)[54] suggests that "Smoking prevalence and levels of addiction to tobacco are highest in the most disadvantaged social groups as are difficulties in quitting due to perceived low self-efficacy and triggers for habitual smoking in terms of stressors". Similarly, the Health Development Agency's 2002 research into the perceptions of cessation products and services among low income smokers found that "Many had tried to give up at some point in their life. However, this was rarely planned and few believed, from the outset, that they would succeed".

Roddy *et al* go on to explain that this lack of PSE in lower socio-economic groups may explain why quit rates are so low despite a reported desire to quit in these groups:

> Despite the fact that deprived smokers are as likely or more likely than advantaged smokers to want to quit smoking, smoking prevalence has decreased markedly in the most socially advantaged groups over the past two decades but remained unchanged in the most disadvantaged smokers, many of whom could be categorised as 'hard core' smokers.

A brief explanation for the apparent low PSE in disadvantaged communities is offered. Bandura explained that low perceived self-efficacy can lead to failure:

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54 Roddy, E; Antoniak, M; Britton, J; Molyneux, A & Lewis, A; (2006). Barriers and motivators to gaining access to smoking cessation services amongst deprived smokers – a qualitative study. BMC Health Serv Res. 6: 147.

> Those who judge themselves as inefficacious are more inclined to visualise failure scenarios that undermine performance by dwelling on how things will go wrong.
> (Bandura, 1989)

The Transtheoretical Model explains, in fact, that the further along the stages towards maintenance an individual progresses, the more PSE they accrue. Experience of success leads to self-belief in the likelihood of success.

Pierpoint and Davidson (2004) suggest that a key reason for the proposed low perceived self-efficacy of the target group is a prevalence of limited self-confidence caused by low education and income levels. In addition, routine occupations offering little opportunity for progression, responsibility or initiative are unlikely to provide fertile grounds for experiences of success.

However, as the previous section explored, another lens through which to view this concept is that of social capital. As has been discussed, limited social capital is often a spiral leading to continued limited future social capital. Limited social capital causes limited opportunities and limited experiences of success. Limited experience of success can lead to low self-esteem and low perceived self-efficacy.

It is possible that research may find a tendency towards low perceived self-efficacy amongst Evelyn smokers. This may be a reason for low quit rates.

9.2.2 Perceived control

It is often suggested that deprived communities have a fatalistic attitude towards health. In terms of behavioural theory, this concept refers to the Health Belief Model and Health Locus of Control Model. The HBM refers to how much an individual considers themselves to be at risk of ill health. The HLCM refers to how much an individual feels they have control over their ability to change their health status. These two models can be used as a framework for understanding potential issues pertaining to Evelyn residents' smoking status.

The HBM explains that the more an individual perceives themselves to be at risk from ill health the more they are likely to act to prevent the likelihood from occurring. The key variables of the HBM are as follows:

- Perceived Threat:
  - Perceived Susceptibility: One's subjective perception of the risk of contracting a health condition
  - Perceived Severity: Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).
- Perceived Benefits: The believed effectiveness of strategies designed to reduce the threat of illness.
- Perceived Barriers: The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.
- Cues to Action: Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take

action. Cues to actions is an aspect of the HBM that has not been systematically studied.

- Other Variables: Diverse demographic, sociopsychological, and structural variables that affect an individual's perceptions and thus indirectly influence health-related behaviour.
- Self-Efficacy: The belief in being able to successfully execute the behaviour required to produce the desired outcomes. (This concept was introduced by Bandura in 1977.)

It may be found that Evelyn residents have limited perceived threat of ill health due to smoking, limited perceived benefits of giving up and perhaps extensive perceived barriers to cessation. In the Health Development Agency's 2002 report into the perceptions of smoking cessation products and services among low income smokers, it was found that "the health risks of smoking were known, but were often the last thing mentioned and were widely deflected or dismissed".

To corroborate this, Des Malone from Deptford Community Forum stated that in his experience, smokers were not afraid of the possible smoking-related killers such as cancer. He suggested that presenting the certainties rather than the possibilities of ill health may have more effect (ie. saying 'you *will* get bronchitis' rather than 'you *might* get cancer'). Limited perceived self-efficacy has already been discussed as a possible explanation of low quit rates in Evelyn.

Secondly, the HCLM suggests that individuals have different types of perceived control over their health which influences action taken to prevent ill health such as giving up smoking.

1. **Internal control:** A person believes they have control over their current and future health through their own choices and behaviour.
2. **External control:** A person believes that powerful others, such as doctors or family, have control over their health.
3. **Chance control:** A person believes the state of their health is down to chance, such as genetics.

Steptoe and Wardel (2003) state that "healthy behaviours have been shown to be associated with stronger beliefs in personal or internal control, and weaker beliefs in chance or external factors. People with high internal health locus of control will choose to engage in health promoting activities and will be more likely to quit smoking, while people with external or chance loci believe they have limited control over their own health. This seems to report further findings from the Health Development Agency, who report that "Non-smoking was widely associated with people who had done better at school, obtained gainful employment and moved away from the area", by definition having more internal control over their life course.

Ross and Wu explain further that "people with high personal control are more knowledgeable about health, are more likely to initiate preventive behaviors such as quitting smoking or reducing alcohol consumption and, as a consequence, report better self-rated health and fewer illnesses than those with a low sense of control. Second, lack of personal control affects health through physiological mechanisms, because experiences of uncontrollability and the resulting demoralization are associated with suppression of the immune system".

Studies have found that both external and chance locus of control can be associated with deprived communities. Calnan (1988) performed an empirical test based on smoking, alcohol and physical activity behaviour and using an established scale for measurement of health locus of control. Two important findings are relevant to Evelyn:

"The people who described their health as poor were more likely to believe that health was a matter of chance than did those reporting good health".
Evelyn has poor self-reported health.

"Higher scores on the change dimension tended to be associated with older people, women and people with little formal education and with manual occupations".

Evelyn has both low education and a presumed high number of manual occupations amongst those employed.

Steptoe and Wardle, however (2003) found that in their survey there were no differences between social classes in beliefs in internal locus of control, but only in chance locus of control. This supports the argument that control beliefs are multidimensional, and that individuals can simultaneously hold strong beliefs in the relevance of their own actions, and in the play of chance.

Steptoe and Wardle (2003) state that "Whether or not this pattern reflects greater fatalism in lower socioeconomic groups is disputed. Blaxter has argued that because people in lower social classes have greater personal experience of chronic disease and premature mortality than more affluent groups, they will also have greater experience both of survival despite the presence of risk factors, and of illness despite healthy lifestyles. Luck or chance may be invoked to interpret these risk factor effects, and may coexist with firm beliefs in personal control. None the less, the association of high chance health locus of control with smoking, sedentary lifestyles, and diets low in fruit and vegetables suggests that such beliefs may be antithetical to healthy lifestyles.

Despite the debate, it is possible that smokers in Evelyn may have a propensity towards having a chance or external health locus of control. Indeed, Gayle Wallace (Neighbourhood Coordinator) commented that residents of Evelyn only access their local GP when something goes wrong and that they do not have a sustained commitment to their own health, most likely because they feel they cannot influence it personally. In addition, the communities with different cultures living in Evelyn may have different culturally-oriented health loci of control. This was highlighted in a discussion with Evelyn pharmacist Ian Schlazer, who commented that the local Vietnamese population tend to believe in fate when it comes to their health, putting ill health down to luck. This has considerable social marketing implications.

9.2.3 Long-term time orientation

Steptoe and Wardle (2003) found a strong correlation between the likelihood of seldom thinking about the future and socio-economic status. They suggest that "premature mortality is more common in lower social status groups" and that "this

might reflect lack of motivation to change on the part of those who foresee a shorter future".

Steptoe and Wardle explain that their study found a "social class gradient in seldom thinking about the future was striking, with nearly half of the respondents in semi-skilled and unskilled classes stating that they did not think about either the short-term or long term future very often". The Health Development Agency's 2002 report into the perceptions of low income smokers into cessation products and services confirms this finding. The report suggests that "the benefits of quitting were well known, but were outweighed by the downsides for most. Again, smokers tended to focus on short-term gain, including saving money and not smelling. Several were unconvinced of substantial health gain if they stopped smoking (and believed fatalistically that any damage to health was already done and irreversible)".

The issue of not thinking seriously about the future is likely to have significant impact over Evelyn smokers' willingness to quit, because the benefits to health of not smoking are perceived to be long term so there is likely to be limited motivation to voluntarily act to improve life expectancy and future health status through quitting.

SUMMARY: Potential influences over smoking behaviour

1) **Smoking is a social norm in Evelyn**
2) **Smoking is likely to be culturally ingrained**

Suggested influences over behaviour and further research required

3) **Deprived communities have limited bridging social capital and strong bonding social capital, which can be negative or positive. The nature of Evelyn social capital needs further exploration.**
4) **Perceived self-efficacy and strong internal locus of control are required to overcome socio-cultural barriers. It is possible that Evelyn residents, as a working class community, may lack these psychological assets.**
5) **Consideration of the future increases with socio-economic status. This may suggest Evelyn residents are less likely to plan to quit for long term benefits of abstinence from smoking.**

9.3 Socio-economic

9.3.1 Deprivation

Steptoe and Wardle (2003) raise the issue of deprivation influencing health behaviour when they suggest that "material hardship" can influence health choices such as smoking. Indeed ex-health secretary Dr John Reid may have been suggesting this when he made his contentious 2004 comment; "As my mother would put it, people from those lower socio-economic categories have very few pleasures in life and one of them they regard as smoking."

The following extract from Cattell's 2001 study of social capital and health behaviours is insightful:

> Jennifer, a Keir Hardie resident in her 40s, expressed it has ''never having had a chance to enjoy life'', and added; ''Life has always been hard . . . I had my family young, so didn't see much of life, I couldn't go out clubbing it and

pubbing it''. Jennifer and her husband are unemployed, to manage she buys from catalogues, but it's coping at a cost. She often cries herself to sleep ''worrying how to cope, who to borrow off now''. In response to debt, stress, bereavement and relationship problems, some residents reported that they turn to smoking to cope.

Another illuminating insight comes from the Health Development Agency's report into the perceptions of smoking cessation products and services among low income smokers[55]. Smoking was associated with numerous perceived benefits (these tended to be seen as outweighing the associated risks), including marking a point in the day or a reward and stress and boredom relief (especially among unemployed people and lone parents).

Socio-economic factors can contribute to health, and particularly smoking, in a variety of different ways. It's known that social and environmental issues such as poor housing, isolation and social exclusion, limited educational or employment opportunities can have a detrimental effect. In addition, lack of knowledge can limit access to jobs and affect lifestyle, e.g. not understanding the factors that can impact on health, like quality of diet, leisure, healthy environment etc.[56] Qualitative studies on poverty have, for example, found that stress, loss of self esteem, stigma, powerlessness, lack of hope, and fatalism can result from poverty and can be linked to negative health outcomes (Cattell, 2001)[57]. Key environmental factors will be explored further in this section.

9.3.2 Education and employment

Shohaimi *et al* (2003) performed one of many rigorous empirical studies which found that "men and women with at least O level qualifications were less likely to be current smokers than those without qualifications." Given the limited education level of many Evelyn residents, this is likely to have considerable implications. Another example is the 31 year longitudinal study by Isohanni *et al* (2001)[58] which found that "adult smoking (at age 31) and prolonged smoking (at ages 14 and 31) were both associated with an approximately two- to sixfold, adjusted odds for educational underachievement".

Ross and Wu (1995) delve further in to the link between low education and smoking prevalence:

9.3.2.1 Work and economic conditions

Ross and Wu claim that the work and economic conditions of the better educated protect health. Manual and routine occupations are more susceptible to redundancy and the better educated are more likely to work full time. Part time work offers less training and less gains of experience. Low income through unstable and part time work causes economic hardship, which negatively impacts health. The ongoing strain of paying the bills on an inadequate income takes its toll. When life is a

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[55] Jackson, N; Prebble, A and Conway Smith, R (2002). Perceptions of smoking cessation Products and services among low income smokers. Health Development Agency Report [online, accessed June 2007].

56 N1 health profile

57 Cattell, V (2001). Poor people, poor places, and poor health: the mediating role of social networks and social capital. Social Science & Medicine 52, pp. 1501–1516

[58] Isohanni, I; Järvelin, M-R; Rantakallio, P; Jokelainen, J; Jones, PB; Nieminen, P; Croudace, T and Isohanni, M (June 2001). Juvenile and early adulthood smoking and adult educational achievements - A 31-year follow-up of the Northern Finland 1966 Birth Cohort Scandinavian Journal of Public Health, Volume 29, Issue 2, pp. 87 – 95.

constant struggle, when it is never taken for granted that there will be enough money for food, clothes, and shelter, people often feel worn down, depressed, and hopeless. This makes people susceptible to disease, decreases self-esteem and perceived self-efficacy and increases their chances of smoking and not being able to quit smoking.

These comments were corroborated by Des Malone from the Deptford Community Forum, who said that smoking is used by local residents as a form of stress relief. “Life is stressful in Evelyn”, he said. He believed that this was is in part due to overcrowding.

Finally, well educated people are more likely than the poorly educated to experience autonomy, which can increase psychological functioning and job satisfaction, boost self-esteem and perceived self-efficacy by increasing experience of success.

Social-psychological resources

Ross and Wu explain, “well educated people have social-psychological resources, including a high sense of personal control and social support, in addition to economic resources.” They explain that education provides skills and information to help people deal with the stresses of life, including a low income, while lack of education makes it more difficult to cope with an inadequate income.

Also, “because education develops one's ability to gather and interpret information and to solve problems on many levels, it increases one's potential to control events and outcomes in life”. A perception and ability to control health has already been explored as a required psychological asset to change difficult health behaviours.

Secondly, Ross and Wu state that less educated individuals, with the added stress already discussed, require social support to manage their health better but that social support is associated with better education. Interestingly, the previous discussion of bonding social capital being prevalent in working class communities would contradict Ross and Wu’s statement. However, it does seem logical that the support of a spouse can be influential over good health behaviours; “Married people experience more regulation of behavior than the unmarried (Umberson 1987), as one's spouse may discourage smoking, drug use, or heavy drinking”. Ross and Wu suggest that the stress of low education and income and the inability to regulate this stress may lead to more break up and domestic disharmony in deprived communities, therefore limiting this form of potential behavioural regulation.

The well educated are more likely to engage with positive health behaviours.

Ross and Wu explain that the well educated are less likely to smoke than the poorly educated because they are more likely to have never smoked and because they are more likely to have quit. They explain that “high levels of educational attainment are positively associated with physical activity, that “the well educated are more likely to drink moderately than the poorly educated” and finally that “The well educated are more likely to get preventive medical care”. Ross and Wu do little to expand on these statements further, but the link is made between smoking in deprived communities and other behaviours which are damaging to health.

Ross and Wu make a convincing argument that lack of education is strongly linked with smoking. To summarise, factors influencing smoking behaviour, which they suggest are directly attributable to poor education, are as follows:

- stress from low income
- stress from unstable employment
- lack of self worth from routine occupations
- lack of personal control
- stressful domestic situations which can lead to lack of immediate social support
- lack of abstinence from other behaviours which damage health

The issue of stress is clearly a recurring theme. Stress is known to be linked with smoking. Smoking is often used, according to ASH, as a mood regulator or coping strategy and reliance on it fulfilling this function can be considered as addictive as the nicotine itself. Several reasons have been posed in the previous discussion as to why stress is particularly prevalent in deprived communities, and these include the unrewarding nature of occupations, low income, disrupted families and a negative physical environment.

Factors such as substandard housing conditions, differential access to health services, and lack of social organisation have been identified as influencing the health of people living in areas with such characteristics.[59] Indeed, the research by Shohaimi *et al* (2003) found that the influence of area based deprivation on smoking status was evident for both genders, with a general trend of increasing proportions of current smokers with increasing residential deprivation quintiles. They also found that the prevalence of people who had never smoked was highest in men and women living in the least deprived areas.

9.4 Demographic pointers

9.4.1 Ethnicity

To recap, Evelyn's ethnic mix comprises:

	White Ethnic Group	Mixed Ethnic Group	Asian Ethnic Group	Black Caribbean Ethnic Group	Black African Ethnic Group	Black Other Ethnic Group	Chinese Other Ethnic Group	Other Ethnic Groups
Evelyn	45.2	4.2	3.23	10.38	25.12	2.67	4.68	4.54

Of this, the most significant populations are

- White British
- Vietnamese
- Somali
- Nigerian
- Kenyan
- Black Caribbean
- Black African
- Polish and other Eastern European
- Indian and Bangladeshi

59 Shohaimi, S; Luben, R; Wareham, N; Day, N; Bingham, S; Welch, A; Oakes, S Khaw, KT (2003). J Epidemiol Community Health; 57: p. 270–276

It is likely that the ethnic mix in Evelyn will have a significant impact over the health of its population and its smoking prevalence. The primary problem is the language issue, which is a clearly significant barrier in Evelyn to accessing services. Doug Eveley from the John Evelyn pub requested posters advertising the smoking ban in Vietnamese because his Vietnamese customers are unaware of it and can not read the English posters he has bought. The photograph below is on the door of the Riverside Youth Club on Grove Street, highlighting the importance of communicating in various languages with clients, many of whom are new refugees or asylum seekers, until English is spoken comfortably:

In addition to language, Des Malone from Deptford Community Forum commented that every ethnic group in the area has a different cultural view of smoking and to date interventions have not been very sophisticated in their methods of conveying the message.

Indeed, the 2nd Black and minority Ethnic Groups Lifestyle Survey 2000 [60], as well as the Health Survey of England, also showed that stopping smoking was a new phenomenon in many BME groups and that cultural and linguistic barriers impaired access of people from these groups to health information and advice. In Lewisham where over 130 languages are spoken, the demand for interpreting service is evidence of this. The most common requests for interpretation were from speakers of Vietnamese, Turkish and Somali languages. These groups were also underrepresented in the use stop smoking and nutrition services. So it is valuable to look at the literature to see what is already known about BME groups smoking and accessing of smoking cessation services in England.

[60] The 2nd Black and Minority Ethnic Groups Lifestyle Survey, HEA 2000

a. Cultural insights

Vietnamese

The philosophy of life of the Vietnamese bears the deep imprint of the various religions in the country. The Buddhist influence can be discerned in the view of life on earth as something transient and unstable. The Vietnamese bear an attitude of acceptance towards life which amounts almost to stoicism. They seem to be content with their fate, no matter how humble it may be. This attitude of self-contentment reflects the Taoist view of life.

In the view of the Vietnamese common man, life on earth is but a temporary stop on his journey to death and other reincarnations. Since death is viewed as inexorable and inherent in the human condition, the Vietnamese accepts it with composure. It was a common custom in Vietnam, especially in rural areas, for people to have a coffin ready in their houses as a preparation for death that may come ten or twenty years in the future. Well-to-do people used to build their own tombs long before they felt they were approaching death. This composure should not be construed as absence of sadness and regret. The Vietnamese believe that, in spite of its seamy side, life is still better than death, which is shrouded in mystery. Death, for Vietnamese, does not mean total disappearance. Only the corporeal frame is disintegrated, and the spirit survives and perpetuates itself in a series of reincarnations.

There are 2 Chinese medicine centres in the area – New Cross Road and Deptford High Street. Sandra Franklin from Monrnington Surgery has spoken to some of her Vietnamese clients and Chinese medicine is popular for treating ailments but not necessarily for ill-health prevention.

A series of focus groups conducted with Indo-Chinese residents of Deptford in 2006 discussing housing found some interesting insights into Indo-Chinese life in the area:

- language is a significant problem, often preventing the access of services.
- Interpretation services are considered to be inadequate.
- Small discussion groups were considered a better way of communicating than telephone interviews.

Caribbean

Old African culture and customs influence much of the religious worship, artistic expression, rhythmic dancing, singing and even ways of thinking in the Caribbean. Spiritual practices such as Junkanoo in the Bahamas, Santeria in Cuba, Voodun in Haiti, and Rastafari in Jamaica are African-influenced movements that have Caribbean origin but a worldwide following. Reggae music and jerk cooking are also Africa-inspired.

Music has been central to Caribbean culture since the days of slavery, when it was a mode of mental survival and a form of recreation. It is characterized by a natural, easy rhythm and multiple ethnic influences, particularly the African drum beat. Dancing everywhere in the Caribbean is an energetic melding of lower-carriage movement, shuffle-stepping, and swaying hips. There is a complex cultural blend to be heard in nearly every musical style found in the Caribbean. A passion for song

and dance is just one part of Taíno culture, while sports and even smoking were popular pastimes as well.

Sandra Franklin, the cessation advisor at Mornington Surgery, (herself African-Caribbean) suggested that there are cultural reasons for the low quit rate among this group in Evelyn. She suggested that she sees so few people of Caribbean origin because smoking is an integral part of the culture. She suggested that people of Caribbean origin lapse a lot because they struggle to come to terms quickly with their health issues. There is a significant problem of diabetes amongst this group and she said she observes sufferers believing they can take some herbal medicine and it will go away. The same can be said for smoking, she believes. It is not considered a truly significant problem and therefore the drive to quit is not apparent and this shows through the quit attempt and success rates.

African

The African population of Evelyn are particularly susceptible to diabetes, hypertension and issues relating to over weight, according to African Community Partnership health worker Aleah Kamruddin.

Somali

Unlike many African nations, Somalia is composed of a single, homogeneous ethnic group. Although Somalis may differ in nuances of local lifestyle, they share a uniform language, religion, and culture, and trace their heritage to a common ancestor. The universal language in Somalia is Somali, an afroasiatic language that is closely related to Oromiffa and more distantly related to Swahili and the semitic languages of Arabic, Hebrew, and Amharic. Although written for many years, a uniform orthography was not adopted until 1973.

The vast majority of the population is Muslem (>99%), and thus Arabic is a second common language. Until the 1970's, education was conducted in the language of colonial rule, thus older Somalis from northern Somalia are conversant in English and those from southern Somalia are conversant in Italian. The government sponsored literacy campaigns in the 1970s and 1980s and education was free at all levels until 1991.

Important religious holidays include Ramadan, Id al-Fitr, Id Arafa, and Moulid. Ramadan is the 9th month of the lunar calendar. During the 30 days of the holiday, people pray, fast and refrain from drinking during the day and eat only at night. An important aspect of this holiday for medical providers to be aware of, is that medications will often be taken only at nighttime. Pregnant women, people who are very ill, and children (usually interpreted as under 14 years old) are exempted from the fast. Some religious observance of Ramadan extends the fast for an additional 7 days. Islamic tradition forbids eating pork or drinking alcohol.

Women usually wear one of the following dresses:

- Direh, a long, billowing dress worn over petticoats.
- Coantino, a four-yard cloth tied over shoulder and draped around the waist.
- Toob, commonly worn throughout Africa
- Hijab, and head scarfs are very common

The common way to greet someone is to say salam alechem (roughly translated as "God bless you") and to shake their hand. Due to Islamic tradition, men and women do not touch each other. Thus men shake the hands of other men, and women shake each other's hands. When departing, the common phrase is nabad gelyo ("goodbye"). Respect is paid to the elders of the community. Elders are addressed as "aunt" or "uncle," even if they are strangers.Common verbal greetings include:

- Assalam Alaikum (Peace be upon you)
- Nabad miyaa (is their peace).
- Subah wanaagsan (Good morning)
- Galab wanaagsan (Good afternoon)
- Habeeb wanaagsan (Good night)

Somali use sweeping hand and arm gestures to dramatize speech. Many ideas are expressed through specific hand gestures:

- A swift twist of the open hand means "nothing" or "no".
- Snapping fingers may mean "long ago" or and "so on"
- A thumb under the chin indicates "fullness".
- It is impolite to point the sole of one's foot or shoe at another person.
- It is impolite to use the index finger to call somebody; that gesture is used for calling dogs.
- The American "thumbs up" is considered obscene.

The right hand is considered the clean and polite hand to use for daily tasks such as eating, writing, and greeting people. If a child begins to show left-handed preference, the parents will actively try to train him or her to use the right hand. Thus left-handedness is very uncommon in Somalia.

As proscribed by Muslem tradition, married women are expected to cover their bodies including their hair. In Somalia, some Somali women wear veils to cover their faces, but few do in the west as they find this a difficult custom to adhere to in society. Trousers are not a generally accepted form of attire for women, but may be worn under a skirt.

As in many Islamic cultures, adult men and women are separated in most spheres of life. Although some women in the cities hold jobs, the preferred role is for the husband to work and the wife to stay at home with the children. Female and male children participate in the same educational programs and literacy among women is relatively high.

Childbearing usually commences shortly after marriage. A woman's status is enhanced the more children she bears. Thus is not unusual for a Somali family to have seven or eight children. The concept of planning when to have or not to have children has little cultural relevance for Somalis.

Somali traditional medicine is practiced by "traditional doctors" who are ususally older men of the community who have learned their skills from older family members. They are especially adept at treating hepatitis, measles, mumps, chicken pox, hunch-back, facial droop, and broken bones. Modalities used include, fire-burning, herbal remedies, casting, and prayer. Fire-burning is a procedure where a stick from a special tree is heated till it glows and then applied to the skin in order to

cure the illness. It is commonly used for hepatitis (identified as when the eyes, skin, and nails turn yellow and the urine turns dark), where the heated stick is applied once to each wrist and 4 times to the abdomen. It is also commonly used for malnutrition (marasmus); when the head seems to be large out of proportion with the body, the heated stick is applied to the head in order to reduce the head size. Pneumonia is treated with fire-burning, herbs, and sometimes percutaneous removal of fluid from the chest. Seizures are treated with herbs and readings from the Koran. Stomach-aches and back-aches are treated with the herb habakhedi, while rashes and sore throats are treated with a tea made from the herb dinse.

Traditional doctors are also responsible for helping to cure illnesses caused by spirits. Somalis have a concept of spirits residing within each individual. When the spirits become angry, illnesses such as fever, headache, dizziness, and weakness can result. The illness is cured by a healing ceremony designed to appease the spirits. These ceremonies involve reading the Koran, eating special foods, and burning incense. The illness is usually cured within 1 or 2 days of the ceremony.
In Somali culture there also exists the concept of the "Evil Eye." A person can give someone else an Evil Eye either purposefully or inadvertently by directing comments of praise at that person, thereby causing harm or illness to befall them. For example, one does not tell someone else that they look beautiful, because that could bring on the Evil Eye. Similarly, Somali mothers cringe when doctors tell them that their babies are big and fat, out of fear the Evil Eye will cause something bad to happen to their child. More acceptable comments are to say that the child is "healthy" or "beautiful."

Kenyan

Currently there are more than 40 different ethnic group in Kenya. The main groups of tribes are the Bantu who migrated from western Africa, the Nilotic people who originated from Sudan and the Hamitic group, who were mainly pastoral tribes from Ethiopia and Somalia. The main tribes are Kikuyu (21%), Meru (5%), Kalenjin, Luyha, Luo (14%), Kisii, Kamba, Swahili, Masai, Turkana. The other large ethnic groups include the Luo, Luhya, Kamba and Kalenjin- There are also some groups of people who form a very small population. This includes the tribe of El Molo.

Found mainly in Southern Kenya, the Massai is one of the most famous of Kenya’s tribes. They believe that their rain God Ngai granted all cattle to them for safe keeping when the earth and sky split. Since cattle was given to the Massai, they believe its okay to steal from other tribes. The Massai worship cattle because it is their main source of economic survival as opposed to education.

The Kenyan official national language is English, and it is wide spoken. There also another national language, Kiswahili. Both Languanges are taught throughout the country.

A large proportion of the Kenyan population are Christians found mainly outside the coastal and eastern provinces. Muslims make up some 30% of the population found in the coastal areas and in the eastern side of the country - the rest is a combination of other minority religions such as Hindus, Buddhists and those who follow their ancestral tribal beliefs.

Nigerian

The most populous country in Africa and the largest in area of the West African states, Nigeria was an early twentieth century colony that became an independent nation in 1960. A country of great diversity because of the many ethnic, linguistic, and religious groups that live within its borders, Nigeria is also a country with a long past. The history of the peoples that constitute the present state dates back more than 2,000 years.

The earliest archaeological finds were of the Nok, who inhabited the central Jos Plateau between the Niger and Benue rivers between 300 B.C. and 200 A.D. A number of states or kingdoms with which contemporary ethnic groups can be identified existed before 1500. Of these, the three dominant regional groups were the Hausa in the northern kingdoms of the savanna, the Yoruba in the west, and the Igbo in the south.

The country's official language, English, is widely spoken, especially among educated people. Apart from English, 400 native Nigerian languages are also spoken, out of which some are being threatened with extinction.

The oil-rich Nigerian economy, long caught in political instability, corruption, and poor macroeconomic management, is undergoing substantial reform under the new civilian administration. Nigeria has seen seven coups in 32 years, during which the military rulers had failed to diversify the economy away from over dependence on the capital-intensive oil sector, which provides 20% of GDP, 95% of foreign exchange earnings, and about 65% of budgetary revenues. The largely subsistence agricultural sector has failed to keep up with rapid population growth, and Nigeria, once a large net exporter of food, now must import food.

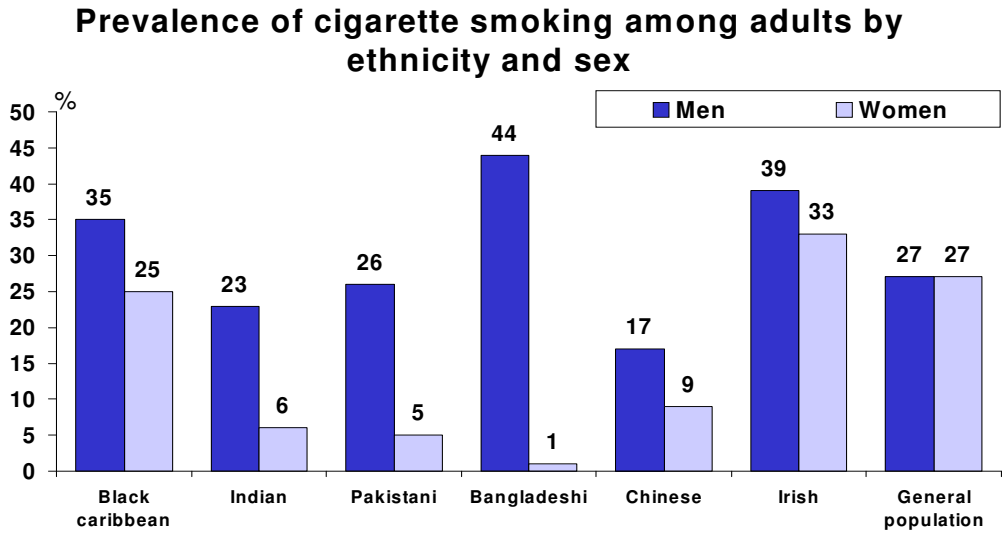
b. Smoking rates amongst BME groups

ASH tells us that the Health Survey for England found that many minority ethnic groups have smoking rates that are lower than that of the rest of the population. An exception to this was the smoking rate among Bangladeshi men, of whom 44% smoked. The survey also found that the proportion of 'heavy smokers' – those smoking 20 or more cigarettes per day - in all minority groups, was lower than the proportion of heavy smokers in the rest of the population (37%). The lower smoking rates among some groups reflects cultural and religious differences, particularly among some Muslim women.

However, rates of chewing tobacco – almost unknown of among the wider population – are a health concern among some minority ethnic groups. Smokeless tobacco is used by some ethnic minority groups, particularly those from South Asia. Chewing tobacco is most commonly used by the Bangladeshi community with 9% of men and 16% of women reporting that they use chewing tobacco. Note these figures are substantially lower than those reported in the 1999 survey which found that 19% of men and 26% of women from the Bangladeshi community said they used chewing tobacco. The difference may reflect a degree of under-reporting by some respondents. For example, self-reported use of all tobacco products was 44% and 17% among Bangladeshi men and women respectively. However, including respondents with a saliva cotinine level indicative of personal tobacco use, the estimates rise to 60% of men and 35% of women.

Tobacco is often consumed in combination with other products. Betel pepper leaf is used to wrap the fillings to form a quid. The leaf has a mint flavour and is considered a mouth freshener. The leaf (paan) itself is relatively harmless: the health risks arise from the tobacco and other ingredients contained in the paan. Ready-made mixtures of snuff are known as Gutka or paan masala which are chewed either on their own or in betel quid. They are prepared by baking and curing a mixture comprising areca nut, lime, spices and tobacco

The following graph illustrates the key ethnic trends in smoking amongst men and women of various ethnic origin.



Source: Erens et al 2001

Around 50% of Evelyn's population is non-white so it is possible to use the variance between the percentage of men and women smoking, shown in the graph above, as a possible reason why so many more men smoke in Evelyn than women.

c. Cessation

In general, stopping smoking appears to be a more recent phenomenon in the minority groups than in the wider population, at least in the English context (HDA 2000a). The table below shows the proportion of people who were ex-regular smokers, among people who had ever smoked, at the time of the second English minority ethnic health and lifestyle survey and the Chinese survey. This shows that a higher proportion of the general English population were former smokers than among the minority ethnic groups. Ex-smokers within the minority ethnic groups tended to report having quit recently. Cessation, then, may not be

Proportion of ex-regular smokers, amongst people who had ever smoked

All of England	Bangladeshi	African Caribbean	Pakistani	Chinese	Indian
46%	17%	28%	26%	10%	35%

Source: HDA *Black and Minority Ethnic Groups in England: The Second Health and Lifestyle*

Survey, (2000a) and HEA *Health and Lifestyles of the Chinese Population in England* (date unknown)

Qualitative research in England uncovered more detail about reasons why people from minority ethnic backgrounds stop smoking. A number of factors were cited as influencing the desire to stop smoking, although many of these were hypothetical and related to possible reasons for giving up in the future. Religious factors were cited across all ethnic groups and Ramadan was cited as an influence to give up by some Muslims. The majority of participants expressed a desire not to give up smoking because they enjoyed it, felt it contributed to their quality of life or because it was a coping mechanism in stressful situations (HDA 2000b). Phung from the Deptford Vietnamese Project explained that in the case of Vietnamese men, who have particularly high smoking rates, smoking and drinking are part of the culture of masculinity. Men she has spoken to have often commented that they don't want to stop smoking because they would feel like they are losing their masculinity or Vietnamese male identify.

d. Cessation services

It is known that in Evelyn, more smokers with a White ethnic background currently access smoking cessation services than those from black and minority ethnic groups but that it is the non-White ethnic groups who have the best quit success rates. Of interest are statistics from the North East, where the Health Observatory tell us that "Smokers from Black and Minority Ethnic groups appear less likely to access services"[61]. In addition, an analysis of the All Wales Smoking Cessation Services found that "Less than 2% of clients accessing the AWSCS are from minority ethnic groups"[62].

However, the national statistics paint picture where BME groups are just as likely to want to give up smoking as White British people. The next table shows the proportion of current smokers who had previously attempted to stop smoking on at least one occasion[63]. In all groups, somewhere in the region of 55-71% of current smokers had attempted to stop smoking on one or more occasion. Figures for successful quitting were broadly in line with England as a whole, where around two thirds of smokers admitted they had attempted to give up smoking previously, but without long term success.

Proportion of current smokers who had attempted to quit at least once

All of England	Bangladeshi	African Caribbean	Pakistani	Chinese	Indian
-	71%	63%	55%	66%	65%

[61] http://www.nepho.org.uk/index.php?c=1095

[62] http://66.102.9.104/search?q=cache:iDcmUKiKvoEJ:www2.nphs.wales.nhs.uk:8080/widerdeterminantsdocs.nsf/61c1e930f9121fd080256f2a004937ed/8a588b40bf6ec759802571cb0042c3bb/%24FILE/AWSCS%2520Annual%2520report%25202005-%2520final%2520versionLD-amend1508%2520-%25203%2520August%252006.doc+ethnic+minority+access+of+smoking+cessation+services&hl=en&ct=clnk&cd=7&gl=uk

[63] This whole section is based on Brown, C (August 2004), TOBACCO AND ETHNICITY:A LITERATURE REVIEW. [Online], *ASH Scotland*. http://www.ashscotland.org.uk/ash/files/tobacco%20and%20ethnicity.pdf

Source: HDA *Black and Minority Ethnic Groups in England: The Second Health and Lifestyle Survey*, (2000a) and HEA *Health and Lifestyles of the Chinese Population in England* (date unknown)

This suggests that the Evelyn figures, which show that fewer BME members are seeking to give up through the provided cessation services, are not likely to indicate that there is no desire to quit. The Evelyn dearth of BME cessation attempts using the provided services is likely to be due to a different reason. For example, Phung from the Deptford Vietnamese Project explained that a lot of Vietnamese men smoke and when they want to give up they go it alone. Many are reluctant to use their GP because of the language barrier, and also there is a significant perception that GPs are for ill health not prevention.

e. Perceived barriers to cessation services

The reasons why members of BME groups are less willing to access smoking cessation services are likely to vary dramatically between areas. However, anecdotal evidence suggests that the ethnicity of the service provider may be influential. North Bradford PCT, for example, reported that "South Asian specialist smoking advisors have increased the number of clients setting quit dates in the South Asian community".[64]

Also, a Glasgow based study found that smokers were more likely to attempt to give up unaided and to seek advice on smoking cessation within their own social circles rather than through professional agencies. There was generally a low level of awareness regarding anti-tobacco agencies, pharmacological aids (e.g. Nicotine Replacement Therapy [NRT] and Bupropion [Zyban]) and prevention materials (ASH Scotland, 2000). Anti-tobacco material was criticised for lacking visual representation of people from minority ethnic backgrounds and it was commented that it was often not suitable for older members of the community (ASH Scotland, 2000).

The majority of participants in the research thought that smoking cessation services would not be able to provide the necessary information and support, in an appropriate manner. Respondents generally felt that inclusive strategies within mainstream services and proactive approaches by agencies in the field would be the most effective way to address smoking with minority ethnic communities (ASH Scotland, 2000).

Some of these findings were confirmed in English studies. The first minority ethnic health and lifestyles survey asked current smokers who have tried to give up about their use of cessation aids (Rudat, 1994).

The table below shows the proportion of people from different ethnic groups who used different methods to help them stop smoking.

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[64] http://66.102.9.104/search?q=cache:LQnTbWvjV7wJ:www.northbradford-pct.nhs.uk/NR/rdonlyres/45C3D816-DCC9-40B8-92E0-978B9465F25C/18257/Item_12_Health_Inequalities_Health_Equity_Audit1.doc+ethnic+minority+access+of+smoking+cessation+services&hl=en&ct=clnk&cd=9&gl=uk

Use of Aids to Give Up Smoking

	UK population	Bangladeshi	African Caribbean	Pakistani	Indian
Help and support from family	22	17	15	21	32
Help and support from friends	15	1	8	18	13
Help and support at work	5	1	7	5	8
Advice from doctor	10	23	9	18	16
Prescription from doctor	5	2	2	8	10
Aid bought from chemist	21	6	7	10	17
Special clinic/group	1	0	1	1	2
Advice booklets	14	1	4	7	14
Counselling	1	1	0	3	<0.5
Alternative treatment	5	1	1	<0.5	<0.5
None of these	46	52	65	48	37

Base: Proportion of current smokers who have tried to give up
Source: Rudat (1994) *Health and Lifestyles: Black and Minority Ethnic Groups in England*
HDA: p97

Social support was most frequently mentioned amongst the South Asian groups, with medical advice also playing a significant role. Other aids, such as Nicotine Replacement Therapy (NRT) or advice leaflets were less frequently mentioned. Across all groups, people who tried to give up smoking were most likely not to use any aids in their quit attempt. Indian smokers tend to rely on support from their family, while Bangladeshis are more likely to follow advice from their doctor (Rudat, 1994).

The first health and lifestyles study revealed that people from minority ethnic backgrounds are more likely than White people to find physical access to their GP (General Practitioner) difficult and feel unhappy with the outcome of the consultation (Rudat, 1994). Many South Asians and Chinese people find it difficult to communicate with their GP, either because of a lack of language skills or due to cultural differences in the expression of symptoms. These findings may have implications for the take up of smoking cessation services in traditional health care settings.

The findings from the Chinese health and lifestyles study suggest that people of Chinese descent are less likely to consult a GP than the general English population or than other ethnic minorities (Sproston *et al*, 1999). Chinese community centres did not appear to play an important role in the lives of the respondents in the ASH study, suggesting that it was unlikely that these were a major source of health information. Although 71% of those interviewed said that they had never visited a chinese doctor in this country, one in ten had done so in the last year, indicating that traditional Chinese medicine and health beliefs still play an important role in the health care for many people in the Chinese community (Sproston *et al*, 1999).

A study on beliefs and behaviours in relation to coronary heart disease among South Asians in England confirmed that information on health was obtained from a variety

of avenues - including informal sources (family and friends), doctors and other health care workers, the media, school, places of work, community centres (Beishon and Nazroo, date unknown). There were significant variations between ethnic groups, different generations and males and females in the sources used for health information. To an extent these differences depended on English language skills and literacy.

The primary source of health advice and information in this ASH study were General Practitioners and most literate respondents in the study had seen leaflets on health issues. Television was a popular method of gaining information for those who spoke English, with local Asian language radio stations, newspapers and magazines also common sources of reference. The workplace, places of religious worship and community centres did not feature highly as sources of health information for South Asians, although Muslims more likely than other religions to gain health information from their place of worship (Beishon and Nazroo, date unknown).

Another study looking at sources of information on smoking among minority ethnic groups in England replicated these findings (HDA, 2000b). For the majority of South Asian respondents the primary source of information was Asian broadcast media (especially television, but also newspapers and magazines, and to a lesser extent radio), especially for older people. People also drew upon their own experiences and those of others in building their knowledge about the risks of tobacco. Many participants thought anti-smoking publicity was important, but perceived the messages as 'overwhelming, inconsistent, confusing and conflicting' (HDA, 2000b: 47). Information from health services was often regarded as inadequate and inaccessible and many were mistrustful of pharmaceutical drugs.

This research suggested that community and religious leaders *could* play an important role in health promotion. Indeed, some respondents, particularly women, stated that smoking was forbidden or disapproved of in their religion and culture. A number of the Muslim participants highlighted that Ramadan was an ideal opportunity to give up smoking (HDA, 2000b).

In addition to smoking cessation, some projects have worked on oral tobacco cessation with South Asian groups. Smokeless tobacco cessation guidelines have recently been issued in England (West, McNeill and Raw, 2004). The guidelines recommend offering advice to stop, combined with behavioural support and counselling, but claim that there is insufficient evidence at present to recommend the use of Nicotine Replacement Therapy (NRT) or Bupropion (Zyban) to aid smokeless tobacco cessation. These guidelines also recommend that health professionals, especially doctors and dentists, should routinely assess and record smokeless tobacco use in patients belonging to relatively high prevalence groups, and that they should educate smokeless tobacco users to the potential health risks and offer advise to stop.

A comprehensive study of British-Asian smokers and their relationship with smoking cessation services was undertaken by White *et al* (2002)[65]. Again, they found that

[65] White, M; Bush, J; Kai, J; Bhopal, R and Rankin, J (2006). Quitting smoking and experience of smoking cessation interventions among UK Bangladeshi and Pakistani adults: the views of community members and health professionals *Journal of Epidemiology and Community Health*;**60**:405-411

motivation to quit was high but most attempts had failed. "Willpower" was the most common approach to quitting. For some, the holy month of Ramadan was used as an incentive, however few had been successful in quitting. Perceived barriers to success included being tempted by others, everyday stresses, and withdrawal symptoms.

Backing up the Evelyn stats, however, is the finding that few participants had sought advice from health services, or received cessation aids, such as nicotine replacement therapy (NRT) or buproprion. Family doctors were not viewed as accessible sources of advice on quitting. Health professionals and community members identified common barriers to accessing effective smoking cessation, including: language, religion and culture; negative attitudes to services; and lack of time and resources for professionals to develop necessary skills.

Summary

- Knowledge about the links between tobacco use and heart disease, oral cancers and respiratory diseases (other than lung cancer) are often poor among minority ethnic groups. There is a particular lack of knowledge and understanding about the health risks of chewing tobacco in South Asian communities.
- Gender, age and culture are important influences on attitudes and behaviours. For example, smoking is accepted and ingrained in Bangladeshi male culture, although it is stigmatised among women and smoking in front of elders is considered disrespectful. These attitudes might have an impact on covert smoking practices and accessing tobacco cessation information and services.
- Language and cultural differences can be a barrier to accessing effective services for some people from minority ethnic backgrounds.
- People from minority ethnic backgrounds are less likely to use pharmacological aids e.g. Nicotine Replacement Therapy and Buproprion (Zyban) when trying to stop smoking. This may in part be due to lack of knowledge about these.
- There are significant variations between ethnic groups, different generations and males and females in the sources used for health information.
- The number of people from Chinese and South Asian backgrounds who work in the restaurant trade may be a significant factor related to tobacco use and passive smoking. In addition, the amount of time spent in the workplace and unsocial hours can present barriers to accessing services.

ASH makes the following recommendations when planning smoking cessation services for BME groups:

- Professionals wishing to help minority ethnic peoples to address their tobacco use need to be aware of the differences in prevalence between and within ethnic groups. They should be aware of the size and distribution of ethnic groups within their locality and be sensitive to cultural, linguistic and religious influences.
- Training courses and information materials should be developed relating to tobacco use and cessation specific to minority ethnic communities.
- There is a need for appropriate information materials relating to tobacco use and cessation services, which specifically address minority ethnic communities and are provided in a range of languages.

- Information on tobacco use and cessation support should be provided for minority ethnic communities in a variety of settings (e.g. in health, community and religious settings).
- Targeted campaigns through community media (e.g. Asian language television and newspapers) may be useful.
- Packaging of paan (and other chewing tobacco products) should include health warnings.

9.4.2 Gender

a. Gender specific smoking prevalence

To recap, the overall smoking rate is 42%, the smoking rate amongst males is 49% and the smoking rate amongst females is 35%. Although nationally there has always been a gap between male and female smoking rates, this gap has narrowed consistently in the last 40 years and in 2005 the national smoking rates by gender were 25% for men and 23% for women. Some more detail may be added to this national picture:

- Men tend to be heavier smokers than women, smoking more cigarettes per day and higher tar cigarettes. Twice as many women as men smoke low tar cigarettes (ASH)
- Women generally feel more dependent on cigarettes than men. Almost half, 48%, feel they are unable to cope without cigarettes compared with 35% of men. Women tend to think of cigarettes as their main source of pleasure and 48% smoke to give them confidence in social situations (ASH).
- Females set more quit rates than males but are less likely to succeed in quitting. (NICE also found that older smokers are more likely to quit than younger smokers and that heavily addicted smokers find it hard to quit. Also that pregnant women, smokers with manual occupations and institutionalised populations all face substantial barriers impeding cessation attempts **(**NICE[66]).

The Evelyn statistics demonstrate that there is a significantly higher percentage of male smokers in the ward than female. This suggests that not only are the rates for Evelyn extremely high, as has already been commented, but that the gap between male and female smoking rates also extraordinary. There is a dangerously high smoking prevalence amongst men in Evelyn.

From the previous section exploring ethnicity issues regarding smoking cessation, it is likely that at least some part of the gender difference in smoking prevalence can be attributed to the cultural influences of smoking behaviour, particularly in Asian cultures. The ASH statistics emphasise that in Indian, Pakistani, Bangladeshi and Chinese cultures, there is a stark difference in smoking prevalence between men and women, the male smoking figures being in some cases four times higher.

It is unlikely that the cultural differences in smoking present in Evelyn are responsible for all of the difference between male and female smoking prevalence. Only just over half of the Evelyn population is non-White. It is worth understanding in

[66] NICE: [http://www.nice.org.uk/page.aspx?o=404622]

more detail, then, issues of gender that are known to influence smoking cessation attempts and success.

b. Smoking cessation

Many researchers have reported a significant difference in the success of the genders using various cessation aids. Munafo *et al* (2004)[67], for example, state that "it is becoming clear that there are likely to be gains made by tailoring existing treatment regimens to individuals on the basis of factors such as sex…"

ASH[68] tell us that men and women smokers are similar in their assessment of the health risks of smoking, but their reasons for stopping differ. Men tend to cite more self-orientated reasons, like improving their own fitness, whereas women are twice as likely as men to want to stop for the sake of their family and children or because of pregnancy. Men are also more likely to cite workplace restrictions as a trigger for trying to stop smoking.

Men are more likely to report pressure from their partners to stop whereas women are more likely than men to be pressured by their children. Both men and women commonly try to reduce their risks from smoking by cutting down or switching to lower tar cigarettes thinking it is healthier. However, smokers are able to compensate by obtaining previous levels of nicotine intake from fewer cigarettes or lower tar cigarettes by puffing and inhaling more intensely. This can result in higher doses of tar and carbon monoxide. Men are more likely than women to rely on cutting down to try to reduce their risk, whereas women are more likely to switch to lower tar cigarettes.

When looking at how men and women go about stopping smoking a clear pattern emerges. Men tend to go it alone and rely on willpower to succeed, whereas women are more likely to have been advised to stop or to seek help. In the ASH study, more women (41%) than men (31%) reported intending to buy nicotine replacement therapies, but interestingly equal proportions of men and women use them. Perhaps women are taking the initiative in exploring nicotine replacement therapies.

The barriers to stopping smoking reflect the different 'bonds' men and women have with their cigarettes. For men, alcohol plays an important part, with three times as many men as women stating they started smoking again while drinking alcohol. Stress and fears of weight gain feature more strongly in women than in men.

c. Implications for social marketing

ASH recommend key messages for male smokers:

- Willpower - there is no need to rely on willpower alone. Investigate other forms of support that are available.
- Addiction - health professionals can advise on cessation products and methods to ease
- withdrawal symptoms.

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[67] Munafo, MR; Bradburn, M; Bowes, L and David, S (October 2004). Investigating subgroups in smoking cessation treatment response: Response to PerkinsNicotine & Tobacco Research Volume 6, Number 5, pp. 865–867.

[68] http://www.ash.org.uk/html/health/html/nsdr99.html

- Personal support - welcome the support of partners, friends and family.
- Temptation - be prepared for being caught off-guard, especially when out drinking with friends.
- Cutting down - the only healthy option is to stop smoking rather than cut down.
- Health risks - these do not just affect the smoker, but families and future children's health.

Key messages for female smokers:

- Emotional support - turn to family, partners and friends for support.
- Confidence - try to understand why you use cigarettes as an emotional prop in social situations.
- Weight gain - put concerns about weight gain into perspective - the damages caused by smoking
- far outweigh the effects of the small amount of weight gained.
- Stress relief - remember that this is probably an illusion - smokers tend to feel less stressed once they have stopped than they did while they were still smoking.
- Brand switching - the only healthy option is to stop smoking rather than switch to lower tar alternatives.

Finally it is worth noting the comments of Gayle Wallace (Neighbourhood Coordinator) and Des Malone (Deputy Head of Deptford Green School), both of whom work from the Deptford Green Extended school. They commented that anecdotally the smoking rate amongst boys in the school appears to be decreasing but the smoking rate amongst girls seems to be increasing. This is thought to be involved with the perception that smoking helps manage weight.

9.5 Additional clues

In order to build up a full profile of life in Evelyn, additional psychographic information may be useful:

9.5.1 Employment

There is considerable unemployment in Evelyn, as has been highlighted by an earlier section. However, of those who do work, some insight into smoking behaviour may be drawn from their type of employment. The following table shows the occupations of Evelyn residents in employment[69].

Ward occupations

Occupation	Ward number	Ward proportion	Rank in borough	Lewisham proportion	London proportion
Managers and senior officials	597	11.0%	18th	14.7%	17.6%
Professionals	568	10.5%	15th	14.7%	14.9%
Assoc. professional and technical	819	15.1%	15th	17.9%	18.0%
Administrative	874	16.1%	11th	16.5%	15.5%

[69] Evelyn, a ward profile: Summary of information

and secretarial					
Skilled traders	457	8.4%	9th	8.2%	7.7%
Personal service	488	9.0%	1st	7.0%	5.9%
Sales and customer service	430	7.9%	5th	6.9%	6.7%
Process, plant and machinery	321	5.9%	5th	4.7%	4.9%
Elementary	865	16.0%	1st	9.9%	9.0%

The largest single groups of occupations are administrative and secretarial, elementary and associate, professional and technical. Notice the relatively low concentration of people in managerial and professional occupations when compared to the borough and London, as well as the relatively high proportion of trade, service, process or elementary occupations.

Anecdotally, Alfred Banya, the Community Development Coordinator also commented on the high number of residents employed in the catering industry, where the unusual and long hours may contribute to the culture of smoking. Nga Ndio from FORVIL also corroborated this, saying that many Vietnamese residents end up working in their own restaurants. Again, Jennifer Taylor, the Town Centre Manager, commented that the Vietnamese community have become well established in Evelyn and have set up cafes and restaurants in the high street. The women, she said, are opening nail bars in some of the hair dressers.

Broken down further still, the main industries of employment are as follows:

Main industries of occupation

Rank	Ward proportion
1	Real estate/renting/business activities 17.6%
2	Health care and social work 13.6%
3	Wholesale/retail/motor trades 13.0%
4	Transport/storage/communications 9.2%
5	Hotel and catering 8.1%
6	Education 6.6%
7	Public administration and defence 6.2%
8	Finance 6.2%

In line with Alfred Banya's comment, the Evelyn ward profile states that "The main industries in Evelyn do not differ greatly from those for the borough in general. However, the hotel and catering industry appears a sizeable employer in this ward, in contrast to other wards where it is not as significant."

9.5.2 Leisure opportunities

There are several pubs and a leisure centre in the Evelyn area. There is a well-established arts centre (The Albany) with a theatre, at least 2 youth clubs and

numerous community groups offering social opportunities. There used to be a café on Grove Street by the 2000 Community Action Centre but this is currently closed.

Other leisure opportunities include the allotments, which are popular, and the events at the 2000 Community Action Centre such as line dancing, aerobics and karate. The John Evelyn pub landlord explained that the Vietnamese men he serves as regulars are keen gamblers and there are several betting shops on Evelyn Street. Deptford High Street has numerous hair dressing salons and nail bars. Deptford Market on Deptford High Street near The Albany is also very popular:

There is evidence of much Christian religious activity in Evelyn. This photograph shows the large church on Deptford High Street:

9.5.3 Politics

As expected given the working class background of the ward, there is a strong Labour influence:

Member of Parliament:	Joan Ruddock, MP (Lewisham Deptford), Labour
Mayor of Lewisham:	Steve Bullock, Labour
Local Council Councillor:	Alicia Chater, Labour
Councillor:	Crada Onuegbu, Labour
Councillor:	Sam Owolabi-Oluyole, Labour

9.6 Competition to behavioural goal

Primary research will be required to establish the key factors that act as competition to Evelyn smokers' cessation attempts. However, the analysis so far can offer some suggestions:

Potential competing factors to smoking cessation for Evelyn smokers

Competing factor	Potential required actions
Smoking is a facet of working class culture	Culture change (very difficult and often taking generations)
Smoking as a coping strategy for stress	Assess and adjust stress-making situations (poor housing tenure, unsafe environment, economic hardship) and support residents in their ability to cope with stress
Smoking as a social pleasure	Provide healthier options for leisure time and information and support to encourage use.
Image of smoking. To some degree, and particularly to teenagers, smoking may still have the image of being 'cool' and adult.	Provide non-smoking role models and counter the culture of 'cool' promoted by tobacco companies. Present the concept that teenagers are being manipulated by commercial marketers.
Cultural norms	In addition to working class cultural norms, members of BME groups will also face cultural and religious barriers to cessation. Smoking for men in the Bangladeshi culture, for example, is by far the norm, suggesting that cessation for Bangladeshi men will have additional barriers.
Gender norms	Men and women smoke for different reasons and in different ways. Smoking is a very public behaviour and there may be considerable barriers for men, for example, in quitting when their pub and drinking culture is inextricably linked to smoking.

9.7 Exchange

The preliminary insight from this chapter will act as a basis for further primary reseach, from which it should be possible to determine a possible credible exchange that a marketer may offer the target group in exchange for stopping smoking.

Exchange is a pivotal concept in marketing. As Hastings (The diaspora has already begun, January 2007, unpublished) explains:

> "The best and worst aspects of life, from charitable giving and health care to drink driving and antisocial teens, are all, at base, a function of human behaviour. We marketers have worked out that the key driver of this behaviour is mutually beneficial exchange (or the lack of it), and have been

> applying the lesson since time immemorial – well before anyone thought to call the activity ‘marketing’”.

At this stage it is not possible to come to any initial conclusions about the exchange that may be possible. It is likely, however, that their foundation may be based on the psychological assets required to overcome considerable barriers. As the discussion has shown, these include personal control and perceived self-efficacy. However, without further insight, whether or not exchanges based on these facets will be credible to the target audience remain to be seen.

10.0 Intervention review

This intervention review section will first list smoking cessation aids which may be used as part of an intervention. Then the interventions found in the literature will be described according to their categorisation into the four domains of social marketing interventions:

Control	Design	Support	Educate
- legislation - regulation - enforcement - requirement - standard setting	- design and engineering for the environmental and physical context - increasing availability - improving distribution	- providing support - servicing support - responding to what people need	- informing - advising - building awareness - persuading - inspiring

Where the information is possible, the review will also include

- Evaluations
- Cost-effectiveness
- Details of who used intervention
- Details of when was intervention used

Where the literature is available, interventions will be included which target non-smokers (prevention) as well as those that encourage smokers to quit. An effort will also be made to review interventions targeting deprived communities and those targeting BME groups.

10.1 Review of intervention aids

10.1.1 Nicotine replacement

Nicotine in cigarettes renders them addictive so that smokers generally find it extremely difficult to give up their habit. Nicotine replacement therapies attempt to substitute the nicotine obtained from smoking with that derived from gum, inhaler or patch, so that smokers are enabled to quit smoking and then gradually become independent of nicotine.

There are two broad types of NRT use; that which enables determined quitters to stop smoking abruptly, and that which enables unwilling quitters to cut down their smoking over an extended period while supported by NRT so that they may eventually become able and willing to attempt to quit altogether. It has also been commented that NRT could be used in a new way, to prompt unwilling quitters to smoke by reducing their craving.[70]

[70] The Pharmaceutical Journal, Vol 277, No 7407 p8, 1 July 2006

Results

A Cochrane Review[71] based on 123 trials, (103 of which contributed to the primary comparison between NRT and a placebo or non-NRT control group) found that NRT achieved 1.5- to >2- fold increases in smoking cessation rates. The main outcome measure used was abstinence from smoking after at least six months of follow up. It was also mentioned that there is some evidence that a combination of the possible delivery methods (gum, patch, nasal spray, inhaler, sublingual tablet or lozenges) is more effective than one alone.

A NICE report[72] reviewed 7 randomised placebo controlled trials, although none of were primarily designed to investigate effectiveness of a smoking reduction in terms of sustained smoking cessation. Results for sustained abstinence from smoking, point prevalence of smoking abstinence, sustained smoking reduction and point prevalence of smoking reduction, demonstrated statistically significant superiority of NRT relative to placebo[73].

However, the proportion of participants that achieved sustained abstinence within 6 weeks was low (about 2% of those in receipt of NRT). Even with NRT support, smokers who had expressed unwillingness or inability to quit in the short term would be unlikely to stop within six weeks. Using a more relaxed criterion of 12 months for sustained abstinence, the NICE review indicated statistically significant superiority of NRT vs. placebo. It was acknowledged that counselling may also be required to eventually achieve a successful cessation. NRT was analysed as being economically viable.

10.1.2 Bupropion

Buproprion, also known as Zyban, does not replace the nicotine a quitting smoker would otherwise inhale through smoking but rather affects some of the messages in the brain to reduce the craving itself. 1 150mg tablet is prescribed to smokers (willing quitters) over 18 years old for a week followed by 2 tablets the next week. In week 2, smoking is stopped.

Results

NICE reported clear evidence that Bupropion is more effective than the placebo. It was shown to be effective in smokers with chronic obstructive pulmonary disease, cardiovascular disease and those who have failed in the past to achieve abstinence. It was not, though, found to be superior to NRT.[74]

10.1.3 Combined Behavioural and Pharmacological Treatments for Smoking Cessation

[71] McNeill, A; (Dec 2001): Smoking and Mental Health: A review of the literature: [www.ash.org.uk/html/policy/menlitrev.pdf]

[72] NICE: http://www.nice.org.uk/page.aspx?o=404622

[73] In the studies, sustained abstinence was defined as abstinence starting within the first six weeks of study.

[74] A rapid and systematic review of the clinical and cost effectiveness of Bupropion SR and NRT for smoking cessation (11th April 2002) [http://www.nice.org.uk/page.aspx?o=30634]

Combined behavioural and pharmacological therapies have been reviewed as being the best approach for treating tobacco dependence (Stitzer, 1999[75]; Peters and Morgan, 2002[76]). Peters and Morgan explain that "all forms of nicotine replacement therapy (NRT) -- gum, patches and inhaler -- and bupropion are safe and effective for increasing smoking cessation rates in the short and long terms. The effectiveness of drug treatments is multiplied when associated with effective counselling or behavioural treatments".

10.1.4 Non-NHS treatment

There are many smoking cessation services outside the NHS which boast success rates higher than the 15% long-term abstinence rate achieved by the NHS services. NICE performed a systematic review of reviews to assess the success of acupuncture, Allen Carr's Easyway, hypnosis, NicoBloc, Nicobrevin, St. John's Wort, aversive smoking, cytosine and glucose in achieving comparable smoking cessation rates.

Results

The NICE review suggested that acupuncture, St John's Wort and NicoBloc are probably not effective. There was insufficient evidence to determine the effectiveness of Allen Carr's Easyway Program and Nicobrevin. Hypnosis has not been found to be more effective than simple advice. Studies of glucose showed mixed evidence of efficacy. Rapid smoking may have some efficacy, but its implementation within the contemporary treatment format is problematic. Cytisine (Tabex) also showed evidence of efficacy[77].

[75] Stitzer ML. Combined Behavioual and Pharmacologica Treatments for Smoking Cessation *Nicotine Tob Res* 1999;1 Suppl 2:S181-7; discussion S207-10

[76] Peters, MJ and Morgan, MC (May 2002). The pharmacotherapy of smoking cessation. *Med J Aust. 20;176(10):486-90.*

[77] NICE: http://www.nice.org.uk/page.aspx?o=404622

10.2 Intervention Reviews

10.2.1 General reviews

Control	Design	**Support**	**Educate**
<u>The English smoking ban</u> This law will come into effect on July 1st 2007, making smoking in public places illegal. This has been explored in a previous section but a summary will be provided here. <u>Evidence</u> Research from other countries, including Norway, suggests that attempts to quit will increase if treatments are made easily accessible. Andrew Hyland, associate member of the Roswell Park Cancer Institute, New York, explained what has been seen in the wake of smoking bans elsewhere: "The air is cleaner and health improves, people support the regulations and support increases over time. Hospitality economies are not devastated and appear to suffer no adverse consequences. When smokers decide they are ready to quit, a smoke-free environment makes it easier for them to stop successfully. For some people, they will decide to quit right away when the law is implemented	Smokefree workplaces NICE reviewed evidence on the extent to which workplace policies stimulate, support and utilise smoking cessation with a view to determining the likely effects of the introduction of national smoke-free legislation in England in 2007. Results It was found that cessation programs aimed at the individual when combined with an institutional approach (providing environmental support) were effective in facilitating smoking cessation. It was also found that smoking restrictions positively impacted the uptake of smoking cessation resources. In addition, Moher *et al* (2003) found consistent evidence that workplace tobacco policies and bans can decrease cigarette consumption during the working day by smokers. They found conflicting evidence, however, about whether they decrease prevalence of smoking or overall consumption of tobacco by smokers.[78] NICE also acknowledged the potential influence of combined	<u>Story-based interventions</u>[80] Ritchie *et al* (2007) suggest that stories exchanged between smokers at different stages of change can be effectively used to prompt cessation by being used to locate the process of change within people's daily lives as well as to enable people to engage in a supportive process with others. The intention to change is perceived by many smokers to be unstable and requires opportunities for longer-term support. Including people at the different stages of change seems to be positive and the report suggests that participants appear to incorporate without difficulty those who are still smoking with those who have stopped. <u>Results</u> Ritchie *et al* (2007) claim that the findings of this study challenge current smoking cessation guidelines and suggest highly structured standardized 6-8 week programs in smoking cessation are insufficient to meet the needs of many smokers. Their study suggests that flexible	<u>Brief interventions</u> The NHS provide brief interventions, where health professionals suggest smoking patients access a cessation service whilst treating them for sometimes unrelated ailments. Brief interventions can be implemented by any health professional from a physiotherapist to a health visitor. NICE recommendations include:[81] ▪ Everyone who smokes should be advised to quit, unless there are exceptional circumstances ▪ People who smoke should be asked how interested they are in quitting. ▪ GPs should take the opportunity to advise all patients who smoke to quit when they attend a consultation. ▪ Nurses in primary and community care should advise everyone who smokes to stop and refer them to an intensive support service (for example, NHS Stop Smoking Services). ▪ All other health professionals, such as hospital clinicians, pharmacists and dentists, should refer people who smoke to an intensive support service (for example, NHS Stop Smoking Services).

78 Moher, M, Hey, K & Lancaster, T, (2003): *Cochrane Database Syst Rev*.(2): Workplace interventions for smoking cessation. CD003440. Update in: Cochrane Database Syst Rev. 2005;(2):CD003440.

or even beforehand.	interventions which combined policy, design and support.[79]	services that offer support to a range of smokers are beneficial and valued. In addition, programs that are tailored to the individual's context and culture, as well as the individual's personal life situation, through the medium of the story, are valued and acceptable to the participants.	▪ Community workers should refer people who smoke to an intensive support service (for example, NHS Stop Smoking Services). ▪ Smoking cessation advice and support should be available in community, primary and secondary care settings for everyone who smokes. Local policy makers and commissioners should target hard to reach and deprived communities, including minority ethnic groups, paying particular attention to their needs. <u>Results</u> ASH[82] tells us that brief opportunistic advice has a low efficacy but because of the huge number of people health professionals see in the course of any year, it can have a very significant public health impact. Brief advice mainly triggers attempts to quit (and may do so in 40% of smokers given such advice) but many

[79] The most effective workplace programs were those with proven effectiveness in other settings. Financial incentives can improve recruitment rates (if not cessation rates), whereas 'buddy' support seems to have had limited effect. Intensive interventions were more effective than minimal interventions and workplace health assessments with feedback may also have a role to play, although evidence was inconclusive. NICE acknowledged the potential for Allen Carr seminars, online smoking cessation support and integrated smoking cessation and occupational health and safety programs, although evidence on the effectiveness of these was limited.

80 Ritchie, D, Schulz, S & Bryce, A, Feb 8th 2007. *Public Health:* One size fits all? A process evaluation-the turn of the 'story' in smoking cessation.

[81] NICE:
[http://66.102.9.104/search?q=cache:iFb6fMZcuklJ:www.gpiag.org/news/smokingcessation/nice_smoking_interventions_quick_reference.pdf+brief+interventions+for+deprived+communities&hl=en&ct=clnk&cd=1&gl=uk]

[82]ASH: [www.ash.org.uk/ntml/policy/menlitrev.pdf]

[83] McCarty, MC; Hennrikus, DJ and Vessey, JT (Dec 2001). Nurses' Attitudes Concerning the Delivery of Brief Cessation Advice to Hospitalized Smokers *Prev Med*;33(6):674-81

84 Eckert, T and Junker, C (Sept 8th 2001). Motivation for Smoking Cessation: What Role Do Doctors Play? *Swiss Med Wkly;131(35-36):521-6*

[85] Ockene, JK (1999). Primary Care-Based Smoking Interventions. *Nicotine Tob Res*;1 Suppl 2:S189-93; discussion S207-10

			smokers will need further support. McCarty *et al* (2001) [83] researched nurses' attitudes and beliefs toward their role in assisting patients with cessation and found that they had a relatively positive attitude toward helping patients to quit smoking. 63% believed that hospitalization was an ideal time for patients to try to quit smoking, and 59% believed a nurse had an obligation to advise patients to quit smoking. Eckert and Junker (2001)[84] researched the effectiveness and frequency of GP brief interventions. They conclude that "physicians play an important role in accelerating the process of quitting among smoking patients. Even brief advice from physicians is effective in doing so". However, in their study although 88% recalled being asked by a doctor about their smoking habits. Only 34% of smoking patients recalled being advised to stop. Eckert and Junker conclude that smoking patients receive brief advice with insufficient frequency and that action should therefore be taken to encourage health professionals not only to question all smoking patients but to advise and motivate them to quit smoking. McCarty *et al* also concluded that efforts should be made to educate staff nurses about the efficacy of brief cessation advice and current smoking cessation methods and practices.

			Finally, Ockene (1999)[85] emphasised this point by stating that "RCTs testing the effect of brief smoking interventions and comprehensive programs delivered in a primary care setting present excellent evidence that such interventions significantly increase patients' smoking cessation rates and that as the dose of intervention increases, the effect increases. Unfortunately, despite widespread dissemination of preventive services guidelines and positive physician attitudes towards such services, the current level of delivery of smoking cessation intervention by physicians in real-world settings is not high, making this a major research and public health concern. Based on this evidence, a social marketing intervention could conceivably have this goal.
	<u>Pay for performance incentive</u> Millett *et al* (2007) researched the impact of pay for performance in smoking cessation with a population of people with diabetes.[86] They performed a population-based longitudinal study of the recorded delivery of cessation advice and the	<u>Buddy systems</u> Buddying is a volunteer-based approach to deliver emotional and practical support. It allows interventions to be delivered within the community and ASH recommend that it is found to be particularly useful in low-income groups.[87]	<u>School-based interventions</u> The ISM's systematic review[88] found school-based programs which were informed by the social influences approach. Social influences theory emphasises "the importance of social and psychological factors in promoting the onset of drug use" and comprises three

[86]Millett, C; Gray, J; Saxena, S; Gopalakrishnan, N and Majeed, A (June 5, 2007). Impact of a pay-for-performance incentive on support for smoking cessation and on smoking prevalence among people with diabetes. *CMAJ:* 176 (12).

[87]ASH: [http://66.102.9.104/search?q=cache:XfBvVV-7qg8J:www.ashscotland.org.uk/ash/files/How%2520to%2520set%2520up%2520and%2520run%2520a%2520Buddy%2520project.doc+success,community+stop-smoking+projects.&hl=en&ct=clnk&cd=6&gl=uk]

[88] Stead, M; McDermott, L; Gordon, R; Angus, K and Hastings, G (2006).

	prevalence of smoking using electronic records of patients with diabetes obtained from participating general practices. The survey was carried out in an ethnically diverse part of southwest London before (June–October 2003) and after (November 2005–January 2006) the introduction of a pay-for-performance incentive. Results The introduction of a pay-for-performance incentive in the United Kingdom increased the provision of support for smoking cessation and was associated with a reduction in smoking prevalence among patients with diabetes in primary health care settings.	The 'buddy' is an individual who is given special responsibility to help a smoker in their attempt to stop, by providing support at regular intervals or as problems arise. They can be from an existing social structure or someone previously unknown to the smoker. They may be a non-smoker, another smoker trying to stop, an ex-smoker, or even a current smoker. In the ASH Scotland Project, 'buddies' are members of the public who have undertaken training to support smokers in their attempts to stop, who are committed to helping and who are non-smokers or ex-smokers. No results have been found which demonstrate the effectiveness of buddying.	major components: psychological inoculation / normative education / resistance skills training *(Botvin, 2000).* Results The majority of systematic reviews and meta-analyses of school-based prevention programmes have found that curricula using the social influences approach, specifically including normative education and practice of resistance skills, are consistently more effective than curricula adopting other approaches such as information-only or 'affective' *(Stead et al 2006)*.
		NHS Support Services The NHS services in England provide various interventions designed to encourage smoking cessation. These include one-to-one counselling sessions or group counselling session. They can be GP, pharmacy or nurse-led[89]. Results	2006 Review of Mass Media interventions aimed at encouraging quit attempts and reinforcing current and recent quit attempts[90] Educational Interventions: Three level 3 studies found an effect of multi channel mass media on smoking cessation, but there is no evidence about which of the mass media components of

McDermott, L; A Review Of The Effectiveness Of Social Marketing Alcohol, Tobacco And Substance Misuse Interventions. *Institute for Social Marketin:; University of Stirling & The Open University.* (http://www.nsms.org.uk/images/CoreFiles/NSMC-R3_alcohol_tobacco_substance.pdf)

[89] Lancaster, T and Stead, L F, 2000. *Cochrane Database Syst Rev:* Individual behavioural counselling for smoking cessation. Vol 2::CD001292

[90] Jepson, R; Harris, F and Rowa-Dewar, N (September 2006). A Review of the effectiveness of mass media interventions which both encourage quit attempts and reinforce current and recent attempts to quit smoking.

		Indicative results suggested that NHS Support Services are effective in the short term of 4 weeks. In the long term of 52 weeks, between 13-23% of the short term successful quitters remain abstinent (based on self-report). ▪ It was found that 20% of pharmacy-delivered interventions achieved CO-validated cessation rates at 4 weeks. ▪ It was found that group intervention may be more effective than those delivered one-to-one, although "both types of intervention are essential for the continuation of the services." 'Buddy' systems were not found to increase the effectiveness of group interventions but did increase the effectiveness of one-to-one interventions. ▪ There was indirect evidence suggesting that inpatient interventions in hospital settings are effective. ▪ External factors such as timeliness and target setting seem to have influenced the effectives of intensive smoking cessation interventions. ▪ There was no significant difference in the effectiveness of individual counselling and group therapy.	the interventions were most effective (or most ineffective). There is level 1++ evidence that found no consistent programme effects on smoking intentions, or behaviour of a social-influences based, school and media- based project No smoking days: There is level 3 evidence that found that a quit rate at three months in the range of 11% (0.7% of UK smokers) can be achieved following No Smoking Day. Other level 3 evidence reported a quit rate at three months in the range of 0.3 to 1.8 % following No Smoking Day in Wales. Another level 3 study indicated that the 'Great American Smokeout' may reduce smoking on the day, but subsequently return to previous levels. Quitlines for targeted populations: There is level 3evidence referring to UK pregnant women and their partners from lower socioeconomic groups, which shows that multi-channel mass media advertising has no evidence of effect on changing smoking behaviour but falls to quit lines increased by 14%. There is level 1- evidence that interventions designed to encourage women cigarette smokers with young children to call for information on quitting have no significant effect on quit rates, but 29% of calls received from intervention sites were from the target audience compared with 10% from the control sites. In addition, there is level 3 evidence that calls to national smokers' help lines on No Smoking Day are typically four times those received on an

			average day mass media. Competitions and incentives: There is evidence from one level 1+ review that shows small effect of Quit and win contests on community prevalence smoking. Less than one smoker in 500 quits because of contests. There is evidence from one level 1&2+ review which shows that competitions and incentives in the community (e.g. workplace, clinics) are not effective beyond six months. There is level 3 evidence that they achieve significant effects in the short term, as 35% of the participants self reported that they had quit two months after the contest. Multi-component community intervention: There is evidence from one level 1&2+ review that multi mass media campaigns (combined with other interventions) are effective in increasing tobacco use cessation. Cessation rates in the intervention groups ranged from 3.9% to 50% with a median of 7% in follow-up periods of 6 months to 5 years. There is evidence from a level 2- review that shows that media campaigns and concurrently implemented tobacco control programmes are associated with a reduction in the net smoking prevalence of between 6-12%. Other level 2- and 3 evidence reported either inconclusive evidence, or estimated the follow-up point prevalence abstinence rate attributable to the campaign was 4.5% after control for test effects and secular trends. There is level

			1 + evidence that found that adding peer group support and lottery incentives to mass mediabased self help interventions led to abstinence levels of 19.5% in control group compared with 30% in intervention group at 2 years. One level 1&2+ review found limited evidence of an effect of community interventions for reducing smoking among adults Interventions targeting young people: There is level 3 evidence that indicates that dissonance arousing messages specifically targeting girls can have positive short term effects on quit rates. 12.1% (7.4% boys and 14.6% girls) of the ample reported quitting smoking. There is level 3 evidence that indicates that graphic mass media messages about negative consequences of smoking among adults has a positive effect on quit attempts among young people (18% of smokers attempted to quit. There is level 3 evidence that indicates that media campaigns advertising internet websites can increase quit attempts. Interventions targeting BME groups: There is level 3evidence which show a positive effect of campaigns developed to target rural male oral tobacco users with culturally appropriate materials. There is level 2+ evidence that multi-component interventions including mass media materials in the Vietnamese language are effective (the odds of being a quitter were significantly higher for intervention participants) in achieving smoking cessation in Vietnamese American men.

			2006 Review of Mass Media interventions aimed at encouraging quit attempts and reinforcing current and recent quit attempts: Differences in intervention effects[91] Gender There is a small amount of evidence from two level 1&2 + reviews that 'quit and win' contests, and community interventions may be more effective for women than men. Ethnic group or culture There is level 1++ evidence that a culturally specific phone-based cessation programme is successful in recruiting young Maori, and was shown to be as effective for Maori as non-Maori at increasing short-term self-reported quit rates. Educational level There is level 3 evidence that presents conflicting results on whether the effectiveness of a nation-wide visual mass media campaigns differs according to educational level. Socio-economic status There is evidence from a level 1&2+ systematic review that suggests that people who enter quit and win contests tend to be predominantly female,

[91] Jepson, R; Harris, F and Rowa-Dewar, N (September 2006). A Review of the effectiveness of mass media interventions which both encourage quit attempts and reinforce current and recent attempts to quit smoking.

			younger, better educated, smoking more cigarettes per day, in the contemplation or preparation stage of change, and to have made more previous quit attempts than those smokers who do not enter the contests. The picture for socio-economic status was not consistent, but a level 3 study reported a link between participation in smoking cessation interventions and income levels (e.g. higher income was associated with greater participation). <u>Ethnically diverse group</u> There is level 3 evidence that televised smoking cessation programmes are effective in reaching an ethnically diverse population of smokers.
		<u>Community pharmacy personnel interventions for smoking cessation</u> Sinclair *et al* (2004)[92] assessed the effectiveness of interventions by community pharmacy personnel to assist clients to stop smoking. The authors selected two trials which met their selection criteria which included a total of 976 smokers. Both trials were set in the UK and involved a training intervention which included the Stages of Change Model; they then compared a support programme involving counselling and record keeping against a control receiving usual pharmacy support. In both studies a high proportion of	

[92] Sinclair HK, Bond CM, Stead LF. Community pharmacy personnel interventions for smoking cessation. *Cochrane Database of Systematic Reviews* 2004, Issue 1.

		intervention and control participants began using NRT. Results One study showed a significant difference in self-reported cessation rates at 12 months: 14.3% versus 2.7% ($p < 0.001$); the other study showed a positive trend at each follow-up with 12.0% versus 7.4% ($p = 0.09$) at nine months. The review suggests that trained community pharmacists, providing a counselling and record keeping support programme for their customers, may have a positive effect on smoking cessation rates.	

9.2.2 NICE report into behaviour change

NICE report into Behaviour Change

The 2006 NICE report 'Behaviour Change: Synopsis of Evidence'[93] found that targeting individuals, interventions which showed a positive effect in reducing tobacco usage include

- advice from health professionals,
- the rapid smoking form of aversion therapy,
- self help materials,
- telephone counselling (compared to less intensive interventions),
- nursing interventions,
- group counselling (which is also more effective than self help) and
- oral examination and feedback for reducing smokeless tobacco use.

In addition, interventions to promote smoking cessation or reduction with pregnant women were generally found to be effective across the range of intervention types and indicate that pregnancy may be a point in the lifecourse that is amenable to positive behaviour change. Relapse prevention interventions were also successful with pregnant women, although this was only supported by a single study.

Less clear, poor quality or inconclusive evidence of effect was found for

[93] http://guidance.nice.org.uk/page.aspx?o=395480

- social support interventions (e.g. buddy systems or friends and family),
- relapse prevention,
- biomarker feedback or biomedical risk assessment,
- exercise, and
- interventions by community pharmacy personnel or dentists.

Interventions that had evidence of no effectiveness included

- hypnotherapy, and
- stage-based approaches to changing smoking behaviour.

Interventions which showed an effect in the workplace (on a community level) included those aimed at encouraging individual's to quit — whether they are more effective than in other settings, such as health clinics, is not clear. Interventions included

- group therapy,
- individual counselling,
- self help materials,
- smoking bans and restrictions and
- competitions and incentives.

Although cessation rates have not been shown to differ significantly, recruitment rates can be improved by rewarding participation, which may be expected to deliver higher absolute numbers of successful quitters.

- Interventions in schools and colleges that showed some effect included education,
- social and refusal skills training,
- positive identity reinforcement,
- individual and group counselling and
- smoking policies and restrictions.

There is some evidence that these interventions are not effective in the long term.

Interventions aimed at the wider community included multi-component interventions and those which use multiple channels to provide reinforcement, support and norms for not smoking. These showed limited effectiveness.

Finally, NICE reviewed 7 systematic reviews which evaluated population level interventions to prevent the uptake of smoking or reduce smoking rates. Interventions which showed evidence of a small effect in preventing the uptake of smoking included mass media interventions. Interventions which show a small effect on smoking cessation include 'Quit and Win' contests and reducing smoking in public places (although the before and after study design makes it difficult to determine the extent to which the outcomes were directly related to the intervention). Other interventions such as interventions to reduce tobacco sales to minors have little evidence of effectiveness.

Review of stage-based smoking cessation interventions
Riesma *et al* (2003)[94] reviewed the evidence that stage-based interventions for smoking cessation are effective.

Results
23 randomised controlled trials were reviewed; two reported details of an economic evaluation. Eight trials reported effects in favour of stage based interventions, three trials showed mixed results, and 12 trials found no statistically significant differences between a stage based intervention and a non-stage based intervention or no intervention. Eleven trials compared a stage based intervention with a non-stage based intervention, and one reported statistically significant effects in favour of the stage based intervention. Two studies reported mixed effects, and eight trials reported no statistically significant differences between groups. The methodological quality of the trials was mixed, and few reported any validation of the instrument used to assess participants' stage of change. Overall, the evidence suggests that stage based interventions are no more effective than non-stage based interventions or no intervention in changing smoking behaviour.

9.2.3 Interventions for BME groups

A mapping exercise was recently carried out in England to find out about black and minority ethnic tobacco prevention resources (Crosier and McNeill, 2003)[95].			
Control	**Design**	**Support**	**Educate**

[94] Riemsma, RP; Pattenden, J; Bridle, C; Sowden, AJ; Mather, L, Watt, IS and Walker, (May 31 2003). A. Systematic review of the effectiveness of stage based interventions to promote smoking cessation. *BMJ. 326(7400): 1175.*

[95] McNeill, A and Crosier, A (May 2003). Mapping black and minority ethnic tobacco prevention resources.

		NHS Asian Tobacco Campaign In May 2001 the Department of Health launched a media campaign targeting first and second generation Bangladeshis, Indians and Pakistanis. The £1million per year campaign aims to reduce tobacco use among all South Asian ethnic groups, raise awareness and understanding of the health risks of tobacco use and raise awareness of smoking cessation aids and support. The campaign involves leaflets, TV, radio and press advertising in minority ethnic media, produced in English and in minority ethnic languages. It also includes an outreach programme targeting cities with concentrated areas of high South Asian populations. Specialist Asian language helplines accompany the campaign. The campaign included the following resources in 6 languages unless otherwise stated (English, Urdu, Punjabi, Hindi, Gujarati, Bengali) • An A5 booklet, 'Deciding to give up tobacco use', • A4 self-help booklets, 'How to give up tobacco use' • Posters (5 languages, not Hindi) • Helpline cards for the NHS Asian Tobacco Helpline open every Tuesday from 1 to 9pm in all 5 South Asian languages (see Section 9) • A4 leaflet outlining the background to the campaign & summary of research findings (4 languages, not Hindi). • National advertising campaigns in specialist Asian TV and radio, and in the press. • A section of the Department of Health's website to support health professionals and smokers with cessation was devoted to the South Asian campaign http://www.givingupsmoking.co.uk/sazone/default.asp **Outreach programme** In addition, there was an outreach programme visiting cities where there were concentrations of South Asian communities. Nineteen local projects were funded. In 2001, five projects were awarded varying amounts of funding totalling £140,555 to develop tobacco initiatives aimed at particular black and minority ethnic communities. These were: • Sangam Association for Women. £3.5K. Running 2 seminars & 6 interactive group sessions for Asian Women. • The Muslim Council of Britain. £25K. Setting up an ethnically sensitive health promotion unit incorporating tobacco use to general health. • The Swaminarayan Hindu Temple. £10K. Preparing tobacco education audiovisual and printed materials for worshippers and training of volunteers. • Multicultural Institute. £53K. Setting up a smoking cessation clinic in Oldham, promoting clinic through community events and providing training for Asian community workers. • Muslim Cultural Heritage. £49,055. Setting up a healthy living lifestyle project.
		Transcultural Tobacco website In 2001/2, the DH also funded the development of a transcultural tobacco website (www.transcultural-tobacco.com). This was intended to be a physical as well as a virtual library focusing purely on transcultural tobacco issues. The website is currently on-line in the form of a pre-launch draft and there is currently no Editor in position. Funding is committed until January 2004. Preliminary feedback included a first user test completed in September 2002 and a monthly reporting system on web hits. It currently

		focuses on the South Asian community. Also the NHS Cancer Plan monies funded a part-time secondment within DH to lead the tobacco and ethnic minority work. <u>Results</u> Generating calls to the helpline: The campaign manager reported that the first three phases of the campaign had achieved high levels of awareness and calls to the helplines (around 60 per day during the media campaign). No comparative data is available to suggest whether other areas of the interventions are more successful than mainstream campaigns. However, the report does claim that "it appears that among black and ethnic minority groups, awareness of the national (non targeted) campaign is significantly higher than awareness of the minority ethnic campaign. This reflects the fact that most individuals from black and minority ethnic groups are more likely to obtain their information about tobacco and health via 'mainstream' media than via minority ethnic media.	
		<u>Cessation services in England with a particular remit to support BME groups</u> **1. City & Hackney PCT plus Islington PCT and Haringey & Enfield PCT** 020 7275 8440, info@daymer.org Smoking cessation service to the Turkish & Kurdish community involving one-to-one counselling Level1&2; clinic level 3; mother tongue telephone support line; health education seminars; community smoking cessation. 2 part-time advisers employed. Publicity for service. <u>Results</u> One to one 4 week self-reported quit rates 36% (233 successes from Jan 2000 to March 2002). Over a 15 month period up to March 2002, 160 smokers had called the helpline. **2. Camden PCT** 020 7530 3517, shahab.ahmed@camdenpct.nhs.uk • Smoking Cessation Activities for *Bangladeshi* Community: Brief and 1 to 1 level 2 support. • S Asian & Muslim Tobacco cessation network. • Awareness training on health effects of tobacco use & access to cessation services for religious & community leaders • Stop smoking during Ramadan campaign **3. Ealing PCT** **020 8893 0251, Mina.Fernando@ealingpct.nhs.uk** Smoking cessation advisers run smoking cessation clinics across Ealing.	<u>The DH national tobacco education campaign</u> Preliminary analysis of findings from the evaluation of the DH's national tobacco education media campaign suggests that levels of awareness, recall and views about the 'salience' of the campaign to individuals, are similar among minority ethnic groups to those of the rest of the population. At all points in time, the levels of awareness were significantly higher than those found among respondents to the NHS Asian tobacco campaign.

		4. Greenwich PCT 020 8694 7322, isaac.ojo@greenwichpct.nhs.uk Encourage uptake of smoking cessation services by black and minority ethnic groups defined above. Train community volunteers for level 2 advisers. Use QUIT translations of resources. **5. Westminster PCT** 020 7287 0904, general@cnhlc.org.uk The Healthy Living Centre offers advice as part of a range ofhealth promotion activities to the local Chinese population. **6. Tower Hamlets PCT** 020 7377 7632, r.e.croucher@qmul.ac.uk A jointly managed project with a community health development agency, Social Action for Health. Provide oral tobacco and smoking cessation services to the Bangladeshi community in Tower Hamlets. Developed from a strong research base, using a locality based outreach approach and bi-lingual gender matched advisers. <u>Results</u> 62% success in both men and women in 2002-2003 (validated 4 week success rates) **7. North East and Yorkshire** 0191 2825970, Ann.Potter@nuth.northy.nhs.uk Trained bilingual people who were then employed on a sessional basis to provide smoking cessation support to their communities. 10 trained, but 2 workers currently. Covers an area in West Newcastle with a smaller area in N. Tyneside <u>Results</u> Since the introduction of the service in late June 2001 there has been a marked increase with 40 Asians accessing the service from July to September 2001. **8. Bradford** 01274 223907, Janet.walton@bdct.nhs.uk Specialist cessation service targeted at South Asian communities – Pakistani, Bangladeshi, Hindu and Sikh. 3 South Asian Development Workers/Smoking Cessation Advisors are employed who raise awareness of health effects and	

		signpost local services as well as setting up and delivering services. Includes a Ramadan campaign. **9. Sunderland PCT** Chistine.Jordan@suntpct.nhs.uk Trained ethnic health workers as intermediate advisers who provide one-to-one support to South Asian clients in their own language. Specialist advisers also run specialist groups for South Asian and Turkish clients, the latter with an interpreter. Use DH/Quitline resources. One workplace adviser at a Nissan factory who provides support to Japanese clients. **10. Teeside** Trained and supported key members of local ethnic minorities population plus trained Intermediate advisers and written information covering Indian dialects, Turkish, Greek, Vietnamese, Somali, Arabic. **11. Leeds Health Focus** 0113 2488866, sales@leedshealthfocus.co.uk Bilingual workers to provide a cessation service to the South Asian communities – Pakistani, Bangladeshi and Indian. **12. Nottingham** New Leaf aims to reduce rates of smoking and tobacco use among minority ethnic groups by providing an appropriate and accessible service. **13. Leicester** 0116 2954142, muj.rahman@llr.hpa.nhs.uk Leicester Tobacco Paan Action Group (LTPAG) as a partner agency to the Leicester, Leicestershire and Rutland smoke free alliance has developed a comprehensive plan to address tobacco use amongst South Asians, including cessation issues that specifically take on board cultural and religious considerations. **14. Walsall PCT** 01922 618328, Rachael.Humphreys@walsall.nhs.uk Employs 0.6 Project Worker Asian Communities to disseminate a locally produced video resource aimed at raising awareness of the dangers of tobacco. Project Worker also facilitates specialist service for Asian community. Eventually will deliver smoking cessation support and produce local leaflets in various languages	

		and make links with local agencies. **15. Hadley** 01952 251498, 07813 325015, Pal.Virdee@shropcomm.wmids.nhs.uk Appointed as a Link Nurse cancer care for the Asian community. Telford & Wrekin area. Part of Help 2 Quit. **16. Coventry Primary care Trust** 024-76246091/6093, Heena.Jabbar@chc-tr.wmids.nhs.uk Increase the uptake of Coventry PCT smoking cessation service for South Asian Groups. Raising awareness. Coventry area. Held first tobacco use in S Asian conference in the UK. <u>Results</u> Ramadan Initiative & Divaali report, 2002[3]. Service uptake by black and minority ethnic groups has increased since this person came into post. **17. Luton** 01582 757635, Camille.alexis@luton-pct.nhs.uk Raise awareness of health implications of smoking and to encourage uptake of smoking cessation activities **18. Bristol** 0117 9595466, Karen.blowers@bristolnorth-pct.nhs.uk Trained 7 Asian men (non health professional) as intermediate advisers, working mainly with men. Bristol North, South and West PCT areas. First non health professional community advisors recruited. Paid £25 per client supported. All GP practices aware of provision & able to access advisors as required. Use tobacco campaign resources, although requesting translated local material now. Discussions underway to provide training for Asian women re passive smoking issues. **19. Gloucester** 01452 429341, Diana.cook@wglospct.nhs.uk Enable easier access to local support services for Chinese speaking people in Glos. Plus leaflet in Chinese. Chinese speaking pharmacist main partner. **20. Rochdale**	

		01706 708001 Working to minimise and stop smoking and chewing tobacco. Currently working on a new project (Bangladesh Health Forum). **21. Preston** 01772 645627, Debbie.mccarthy@prestonpct.nhs.uk To increase awareness of the harm associated with tobacco use within the 8 inner city wards, especially aimed at the black and minority ethnic community. Provide cessation sessions and one to one counselling. 20 hours community support workers at A&C grade 4 with relevant cultural & language skills. **22. Liverpool** 0151 707 1555, Jenniferpiet@centralliverpoolpct.nhs.uk Interpreter obtained via City Council dept. Numbers small. Currently looking at developing a service for the Yemeni community within **23. Central Liverpool.** 0151 794 8829, mohameda@roycastle.liv.ac.uk To promote the Liverpool Smoking Cessation Service (Roy Castle Fag Ends) to the Yemeni community. Initially via stands at health fairs arranged by Liverpool Yemeni Arabic Club. Approach came from the Yemeni Community to Amel who is a Yemeni who was working at the smoking cessation service.	
			<u>Stop smoking during Ramadan (London)</u> Activities were carried out across London, in 49 mosques and across 21 PCT areas. A coordinator was employed for 12 weeks and community outreach workers for a period of eight weeks. <u>Results</u> The findings of 3 surveys suggest high levels of agreement that Ramadan was a good time to quit smoking and an increase in knowledge after Ramadan about sources of help. However, it is hard to draw definitive conclusions based on the sampling methodology. The majority of the mosque sample recalled information on Ramadan, mostly from radio or television. The majority

			also reported seeing the calendars and knew how to get the number of at least one helpline. No details of funding were provided to allow any cost-effectiveness analyses.
		Telephone helplines There is a widely acknowledged duplication in the national provision of telephone helplines for people who speak a range of minority ethnic languages and who wish to obtain information and advice about how to quit smoking or to quit using tobacco. The range of languages in which smoking cessation advice and support is offered at a national level currently, reflects the bias towards South Asian groups. There is a gap in knowledge about the needs of 'new communities' for this type of service – but consideration should be given to extending provision to meet the needs of people whose knowledge and use of the English language is poor. The two main providers of the national telephone helplines are the NHS and QUIT.	Manchester Ramadan Initiative (2003) The Manchester Ramadan initiative was funded by British Heart Foundation, Manchester Smoking Cessation Service, Bury & Rochdale Smoking Cessation Service, Rochdale Dental Access Centre, Muslim Council of Britain, Islamic Society of Britain. Results Nearly 600 people were seen during the stop smoking awareness sessions in the mosques, mostly in a group setting. There appeared to have been a slight increase in the number of Asian smokers attending the smoking cessation services. 41 Asian smokers were seen by the services from September to November 2002 compared with 32 during the same months in 2001. No success rates were given. The evaluation report included a discussion of the way forward. One comment was that the timing of the initiative could be brought forward to a month or so before Ramadan, to encourage people to stop in advance of Ramadan. This was because during Ramadan, mosques and Imams are extremely busy and Ramadan itself may be quite a difficult time to stop smoking as '*there is a sense of waiting until sun down and then 'having to make up for lost time' with both smoking and eating*'.

9.2.4 Interventions for deprived communities

Control	Design	Support	Educate
		Social Marketing Smoking Cessation Programme for Pregnant Women in Sunderland (Dental School University of Newcastle upon Tyne April 2002 onwards). This project aimed to increase the uptake of smoking cessation services and quit rate among pregnant women (mainly from deprived areas, social class C2D and E) in Sunderland. Its development was underpinned by qualitative research, which explored what it was like to be a pregnant smoker in Sunderland, and provided insights into the particular issues facing smoking pregnant women. The research found that many women feel awful and that their baby is seen as the priority (not them) when they are pregnant, that they are information poor, that the body language professional can be inhibiting and that they don't want to be nagged. The intervention was developed based this insight. It included proactive recruiting and support for smoking women via a dedicated worker, home visits, design and pre-testing of new marketing/information material and role play training health professionals to engage more effectively with smoking women. Results The impact of the project was impressive. During the intervention, there was a 10-fold increase in the number of women setting a quit date and quitting whilst pregnant.	
		North Staffordshire Smoke Busters Club Jinks and Linnell (2006)[96] evaluated a young person's smoking cessation club – a Smokebusters club. The authors claim that Bruce and van Teijlingen (1999) reported that there were 68 Smokebuster clubs in Britain and several more in Belgium, Japan, Greece and France. Smokebuster clubs have set up as an alternative to school-based programmes which Mitchell (1994) relates have failed in Britain to demonstrate an enduring impact on young peoples' smoking behaviour. The aim of the club is to reduce the prevalence of smoking and to help reinforce non-smoking behaviour in young people aged between 11-15 years old in North Staffordshire area of the UK. The club has been in existence since 1994. Any young person can join the club, whether or not they smoke. The club is designed both to help young people to stop smoking and also to reinforce the dangers of	

[96] Jinks, A and Linnell, S (2006). Evaluation of a smoking cessation club for young people. *Health Education Volume 106 Number 6 pp. 425-436.*
[97] http://www.renewal.net/Nav.asp?Category=:health:health%20issues:smoking

		smoking to non-smokers in order to deter them from starting. When a young person joins they receive information leaflets, free items and money off tokens for local young people's venues. Members also regularly receive copies of the club magazine. Additionally, the club has regular advertising slots on the local radio. Famous sporting personalities feature in the radio advertisements supporting smoking cessation. Finally, some youth workers organise activities for Smokebuster members, ranging from producing murals to having discussions with young people about smoking cessation. These youth workers are based in youth clubs where there are high levels of deprivation. <u>Results</u> Club users were surveyed using a postal survey. Those who replied (16%0 wanted more information about was passive smoking (54.3 per cent, *n*=238), followed by tips for giving up smoking (49 per cent, *n*=215), how smoking affects the environment (47 per cent, *n*=206) and how smoking affects health (47.5 per cent *n*=208). In the questionnaire, a number of suggestions were given about improving the Smokebuster club. These suggestions were again generated from the focus group work conducted prior to undertaking the main study. It was found that the most popular way of enhancing club membership was increasing the age of membership to 10 to 16-year-olds (71.6 per cent, *n*=314). Other popular ideas were placing posters advertising the club and featuring famous people in places used by young people (70.3 per cent, *n*=308) and using photographs in the club magazine to demonstrate the physical effects of smoking, such as for example, photographs of the lungs of smokers (70.3 per cent, *n*=308). The least popular way of promoting the club was having school league tables concerning club membership (44.2 per cent, *n*=194). Other less popular ideas were having famous football team members advertising the club (52.7 per cent, *n*=231) and publishing a diary of someone giving up smoking (59.1 per cent, *n*=259). There was a general feeling expressed by the young people that responded to the survey that the club could provide more active advice and help for those actually wanting to give up smoking. For example, one respondent suggested initiating a help line, another that “Quitting Smoking” packs should be provided to club members and that nicotine replacement patches could also be provided. There were a number of instances of members saying that relatives had given up smoking due to their intervention. For example, there was one contribution written by a parent explaining how she had reduced her smoking due to pressure from her daughter. There were many suggestions concerning how to improve the club magazine. It was found that these comments could be grouped around design issues such as the magazine being bigger, being issued more frequently and increasing the use of real life stories.	

There were also some suggestions made concerning club competitions and prizes. For example, many of the young people surveyed suggested that the club competitions should be more challenging, more varied, more frequent and with better prizes or rewards.

A number thought radio advertising of the club needed to be more frequent and more focused on young people. There were also suggestions that more media outlets could be used to advertise the club and the club's magazine should be available in local shops. Some of the young people surveyed suggested setting up a club web site and others that the use of car stickers may help advertise the club more widely. A number of respondents also thought schools ought to be more involved in the club. A large number of the young people surveyed also suggested that a reward or discount system for club members would be a good, but only if it was based on young people's like and dislikes.

There were a large number of comments that revealed that the young people surveyed wanted to meet with other members of the club. Suggestions of venues and locations were varied and included ideas about setting up a Smokebuster's youth club, and organising day trips, outings and social meetings combined with professional advice on smoking and how to stop smoking. A common issue throughout this theme was that non-club members could accompany club members to events, with the aim of increasing recruitment to club.

The final data theme concerned feelings of being a club member. It was found that the majority of respondents stated that the Smokebuster club was a good idea, with many concluding that the club was “so good that there was no need for change”. Some respondents thought club organisers tried to hard to look cool.

Dudley Smoking Cessation intervention for pregnant smokers[97]

Dudley is a deprived area of the West Midlands. It has higher than average infant mortality rates Dudley is a large metropolitan area of the West Midlands, about nine miles west of Birmingham. Stillbirth and infant mortality is 31% higher than the national average.

The project provides individual support for pregnant smokers, partners and families. The method of delivery:

- Intensive one to one support for the pregnant woman, her partner and their families in their own home environment.
- The woman is offered an appointment within two weeks of referral and receives supporting literature.
- The first visit is to discuss the woman’s motivation and to give her advice about planning their own quit attempt and the use of nicotine replacement (NRT) if necessary
- Regular visits and contacts follow throughout their quit attempt and monitoring data for the Dudley Quit Smoking Programme are used along with documentation in the patient’s hand held

		notes, smoking activity card and hospital antenatal care plan. - The patient receives support throughout the pregnancy, which has been found to help reduce relapse. <u>Results</u> The service has achieved very high quit rates and has learnt many lessons on implementing the service The Dudley service has been found to be one of the most successful services regionally and nationally, with a 46% quit rate at four weeks in 2001/02. However, many referrals were for women who are not ready to quit, so "did not attends" were inevitable. Telephone contact prior to the visit has however helped reduce wasted journeys. Motivating staff and educating them has helped to bring a steady increase in good quality referrals. Continued support through pregnancy has reduced relapse rates. Even if a mother relapses, she is more likely to set a new quit date if visits by the smoking and pregnancy advisor are continuing. Some women still feel uncomfortable in receiving help to quit smoking. The initial visit has proved beneficial for these women to have access to good quality literature, advice and encouragement. Occasionally patients report they have quit and request a visit to check their carbon monoxide reading. This underlines the importance of supporting informed choice. Experience in Dudley suggests the following factors have helped it to achieve success: - Early referrals to the smoking and pregnancy advisor from GPs and practice nurses are encouraged, as the advisor has the specialist knowledge and time to help and support the pregnant woman and her family. It is vital that all health professionals give evidence-based advice; encouraging women to quit rather that cut down. All health professionals who deal with pregnant women should attend an update session on smoking and pregnancy. - The specialist midwives need to write a Patient Group Direction for the supply of NRT in pregnancy. This benefits the patient, the smoking and pregnancy advisor and other health care professionals. It leads to less conflicting advice and allows for better use and variation of NRT products. It encourages setting an earlier quit date and allows for a more holistic approach and better continuity of care. - The use of NRT should be offered as early in pregnancy as possible. This is after discussion on the patient's smoking history and previous quit attempts. The risk is that trying to quit smoking without NRT can lead to an unsuccessful quit attempt, which may discourage the mother from trying again in their pregnancy. - Health professionals within the clinical setting can test for carbon monoxide levels with pregnant smokers, record the result in the patient's hand held notes and explain its significance to them. This has helped women to consider the effects that their smoking has on their pregnancies.	

		- Student midwives should have smoking and pregnancy awareness training included as a mandatory module in their midwifery training. Smoking in pregnancy is the most significant cause of complications and increases in perinatal mortality and illness. But midwives are still reluctant to discuss smoking with their patients due to lack of knowledge - and therefore confidence - in discussing this important issue. - Relapses after the birth may be reduced with the help of a Health Visitor who can incorporate her professional role and one of a smoking advisor. This is an area of development that should be considered in the future. - Specialist 'cessation' counsellors should give behavioural support to pregnant smokers who want help with stopping. Staff should be specially trained and have protected time to give this support. - Pregnant smokers should be offered specialist support to stop smoking. Although only a minority of mothers may take up this support, the evidence shows that it can be effective. In general it should be made as convenient as possible for the mother to receive this support. Pregnant women can be referred quickly on to the specialist service where they are seen on a one to one basis or in a group, can have home visits and an easy referral system from the midwifery service. - Pregnant smokers should be advised to stop as early as possible and the advice recorded in the notes in a readily accessible form. - Pregnant mothers should receive clear, accurate and specific information on the risks of smoking to the foetus and to themselves and be advised to stop smoking. - Clinicians, midwives, and other staff who may be involved in discussing smoking with patients or clients need adequate training to enable them to do this effectively.	
		<u>QUIT smoking and poverty intervention</u>[98] In 1996 the national smoking cessation charity QUIT, set up a three-year trial of its Poverty and Smoking Project. The aim of the Project was to develop a strategy to combat the lack of credible smoking cessation support services accessible by those smokers on a low income. A dual strand approach to help low-income smokers who want to stop smoking was adopted. This involved the establishment of a Community Adviser (Peer Education) Programme and Training for Professionals Programme. Initial pilots took place in Hackney in London, and mid-Suffolk in the East of England- though the programmes now operate across the country. The Poverty & Smoking Project targeted both inner city and rural areas of social deprivation across England. The first pilot of the Community Adviser Programme took place in the London Borough of Hackney (the third most deprived local authority in England) followed by programmes in Maltby (a former steel-works town with an unemployment rate twice the national average). The first rural pilot of the Community Adviser Programme took place in Mid-Suffolk.	

[98] http://www.renewal.net/Documents/RNET/Case%20Study/Quitpovertysmoking.DOC

		Drawing on expert advice and a review of good practice, a two-pronged approach was developed – one focusing on peer education, the other on training professionals. QUIT brought together a number of senior professionals from a range of appropriate fields to advise them. The members of the Advisory Group included experts in the fields of social work, housing, money advice, poverty and smoking cessation. They also looked at earlier projects that have worked on this issue such as Action on Smoking and Health (ASH) in Scotland. The Community Adviser Programme aimed to recruit and train ex-smokers from low-income communities The Community Advisers recruited and ran their own local stop smoking groups for six weeks. The groups sought to provide low-income smokers with peers who could support attempts to quit and understand any issues that may act as barriers to stopping smoking such as spending an evening in the local pub and other stresses in the neighbourhood. QUIT trained local people to run stop smoking groups in their own communities. This helped to overcome barriers created by trainers with very different backgrounds to the client group. It also encouraged neighbours to help neighbours, which raised awareness and provided the opportunity for local people to make informed choices. Community Advisers were recruited either via word of mouth using local connections and networks or through an advertising campaign comprising local press, posters and libraries. A difficulty with this project was persuading ex-smokers in low-income communities to come forward to train as peer educators. However, it is worth finding successful role models because they can demonstrate effectively that stopping smoking is possible and show the benefits in a real and tangible form. The Community Adviser also has credibility, as their life experience is similar to that of their client group. QUIT keyed into existing community networks and used targeted local advertising to recruit the Community Advisers. By using local contacts this helped the recruitment process of the groups. The strength of word of mouth to recruit participants proved a more powerful tool than posters or local press advertisements. <u>Results</u> Almost 40% of those taking part stopped smoking, and almost 20% were still not smoking a year later. But participants also reported raised self-esteem. <u>Evaluation</u> An independent evaluation programme was commissioned to assess the impact of the project. This focussed on the following: - Achieving smoke free status built the self-esteem of many of the participants who believed they had not achieved much before. It became a catalyst for making other changes in their life.	

		- Skills learnt during the sessions were also found to be transferable and instrumental in helping people seek paid employment. - In total 279 respondents took part in the smoking cessation programme, which involved weekly smoking cessation sessions over a period of six weeks. Of these, 252 were smokers and 27 were ex-smokers at the first session. - By March 1999, at the end of all the sessions, the percentage of smokers who had given up was 38%. - It was recognised that a longer time span was required in order to measure the success of the programme and to this effect telephone recall interviews were conducted with participants some 11 to 12 months after they had attended the QUIT sessions. This provides a more realistic long-term view of the cessation rate amongst attendees of the sessions. Overall, 21% of the sample remained non-smokers at this stage. However, owing to the difficulty of re-contacting people after twelve months and budgetary constraints, this was based on a sub-sample (107 participants) of the original sample.	
		<u>Horden and Easington Colliery Pathfinder, Easington</u> The Pathfinder comprises two former mining communities in the north east of England situated between Hartlepool and Sunderland, with over 6,000 households and a population of over 13,000. There is a high rate of teenage pregnancies, lower than average life expectancy, high rates of chronic heart disease and cancer, smoking, obesity and alcohol consumption Amongst other interventions, there was a Smoking Cessation Programme implemented, which focused on pregnant women and their families. The Pathfinder employed a smoking cessation advisor who is an integrated member of the Sure Start team. The advisor works in clients' homes on a one-to- one nationally-recognised psychological evidence-based approach combined with Nicotine Replacement Therapy. Clients are also offered other support for example referral to Sure Start team for children's behaviour management and support from the young person's development worker. The Pathfinder has also initiated a Substance Misuse Development Programme to address the issue of substance misuse and is employing a substance misuse development officer based in the PCT drugs training team, to provide young people, with drugs education.	

9.2.5 International case studies

Control	Design	Support	Educate
			<u>Computer-tailored cessation program in French-speaking Switzerland[99] based on TTM.</u> In this study, a RCT was used to test the effectiveness of a computer-

[99] Etter, JF and Perneger, TV (Nov 26th 2001). Effectiveness of a Computer-Tailored Smoking Cessation Program: A Randomized Trial. *Arch Intern Med;* 161(21):2596-601

			tailored cessation program on daily cigarette smokers who wished to participate (N = 2934). A mean of 1.5 times per 6 months, participants in the intervention group received by mail a computer-tailored counselling letter based on their answers to a questionnaire and stage-matched booklets. The counselling letters were tailored to the participants' stage of change level of tobacco dependence, self-efficacy, and personal characteristics. <u>Results</u> Abstinence was 2.6 times greater in the intervention group than in the control group. The program was effective in "precontemplators" who were not motivated to quit smoking at baseline and was effective regardless of

			perceived difficulty in quitting smoking at baseline.
		Dutch heart health intervention (1998 – 2003) Ronda *et al* (2003)[100] evaluted the Maastricht heart health intervention. The community project attempts to encourage the general population in the Maastricht region to reduce their intake of saturated fat, to stop smoking, and to increase their level of physical activity. In order to apply the intervention framework, nine local health committees were set up. Each health committee consists of approximately ten members who are generally representatives of local organizations that may play a key role in healthy behavior promoting activities. Also, each committee is supported by a health educator from the RPHI Maastricht, a social worker and a civil servant from the municipality. The aim of the health committees is to organize within their area or municipality, activities that facilitate and encourage people to adopt a healthier lifestyle. Examples of ongoing interventions include computer-tailored nutrition education (Brug *et al*., 1998), nutrition education tours in supermarkets (Van Assema *et al*., 1998), a regional campaign to promote physical activity among individuals over 55 and a regional smoking cessation campaign (Ruland *et al*., 2001). Results A considerable percentage of the respondents were in the precontemplation stage towards changing the CVD risk behaviors, and self-efficacy towards smoking cessation, perceived social support towards changing the CVD risk behaviors, the perceived behavior of others, and the intention towards changing the risk behaviors were far from optimal. Previous research on dietary change, smoking cessation, and exercise behavior has shown that psychosocial factors such as attitudes, perceived social influences, and self-efficacy expectations may differ between stages of change (Brug *et al*., 1997; Lechner and De Vries, 1995). A recent study on exercise, for example, found that attitudes, perceived social support and self-efficacy were lower among precontemplators than among people in contemplation and preparation (Ronda *et al*., 2001). As a consequence, changing attitudes, improving self-efficacy and creating a supportive (social) environment may be especially important among precontemplators. The appropriateness of the choice of activities is confirmed by recent Dutch research with respect to health and its determinants. The population itself regarded dietary behavior and physical activity as the most important determinants of health. In addition, smoking behavior was ranked high (Commers and De Leeuw, 2001). The results at the organizational level show that there are good opportunities for involving various organizations in the health promoting activities incorporated within Hartslag Limburg, as well as for increasing collaboration between these organizations in health promotion.	
		Dental Health intervention Binnie *et* al (2007)[101] reviewed the role that the dental team can play in helping their patients to quit smoking. Their study aimed to determine the	

100 Ronda, G; Van Assema, P; Ruland, E; Steenbakkers, M and Brug, J (2003). The Dutch heart health community intervention "Hartslag Limburg": evaluation design and baseline data. Health Education Volume 103 Number 6, pp. 330-341

101 Binnie, VI; McHugh, S; Jenkins, W; Borland, W and Macpherson, LM (2007). A randomised controlled trial of a smoking cessation intervention delivered by dental hygienists: a feasibility study. BMC Oral Health, 7:5

		feasibility of undertaking a randomised controlled smoking cessation intervention, utilising dental hygienists to deliver tobacco cessation advice to a cohort of periodontal patients. One hundred and eighteen patients who attended consultant clinics in an outpatient dental hospital department were recruited into a trial. The intervention group received smoking cessation advice based on the **5A**s (ask, advise, assess, assist, arrange follow-up) and were offered nicotine replacement therapy (NRT), whereas the control group received 'usual care'. <u>Results</u> At 3 months, 9/59 (15%) of the intervention group had quit compared to 5/57 (9%) of the controls. At 6 months, 6/59 (10%) of the intervention group quit compared to 3/57 (5%) of the controls. At one year, there were 4/59 (7%) intervention quitters, compared to 2/59 (4%) control quitters. In participants who described themselves as smokers, at 3 and 6 months, a statistically higher percentage of intervention participants reported that they had had a quit attempt of at least one week in the preceding 3 months (37% and 47%, for the intervention group respectively, compared with 18% and 16% for the control group).	

9.2.6 Case studies

Control	Design	Support	Educate
		<u>Scottish story-based intervention</u> The UKPHA (Scotland), the STCA and CHEX, in partnership, organised an event on smoking, mental health and well-being in December 2006, funded by the Scottish Executive. The event employed a structured 'story dialogue technique'. This allowed those with experience of either giving up smoking, or supporting others to give up smoking, to relate their experiences, and all participants to consider what insights arose from those experiences. <u>Background</u> The story-dialogue technique was devised by Ron Labonte and Joan Feather, Canadian health promotion	<u>Regional media campaign:</u> <u>4000 reasons to be Serious.</u> Deadly Serious Campaign (Heart of Mersey, December 2005) This was a two-week campaign undertaken in town centers across Greater Merseyside to raise awareness about the impact of secondhand smoke. Its key message highlighted the deadly chemicals that are found in secondhand smoke, and the right of that everyone has to breathe clean air at work, which

		experts to bridge the gap between theory, research and practice in health promotion. It is a structured, participatory research method which takes place in small groups and involves the following stages: 1. Establishing a 'generative theme' for the event, which captures key tensions and issues for the target audience 2. Agreeing the ground rules (confidentiality, etc.) 3. Listening to the story, told by the storyteller, who has been briefed beforehand 4. Reflection circle, when other group participants say in one sentence how they feel about the story 5. Structured dialogue when four types of questions are asked: what? (descriptive), why/how? (explanatory), so what? (synthesis) and now what? (implications) 6. Creating insight cards – distilling the key lessons from the story and structured dialogue 7. Creating categories – grouping the insights into common themes. The purpose of the story-dialogue technique in this event was to help practitioners gain insights for improving or changing practice in smoking cessation, which arose directly from the experiences of the storytellers. There were five story groups at the event, each with one main story-teller (in some cases supported by another person). The stories, and the insights that arose from the story-dialogue sessions, are detailed below. **Ann's story – 'It takes as long as it takes – one-to-one support for a long term smoker with a psychiatric history'** Ann had a long term mental health problem. She wanted	includes bars. It was spearheaded by Heart of Mersey Charity, in partnership with local health organisations and local authorities. The campaign was market-tested and subject to an expert review from Tobacco leads and key marketing professionals within public health. The campaign included billboards, posters and leaflets, as well as a pro-active team of staff who were positioned in key locations giving out the mask shaped leaflets, and emphasising the facts around secondhand smoke to the public. These activities were supported by an interactive website, where the amount of toxic chemicals someone absorbs in your workplace – or bar – could be calculated. To date, feedback from the location team and public has been positive and has suggested that people valued the mask message were not just being about public health. **Current government stop smoking campaigns** A key strand of the Government's tobacco control program is the provision of an ongoing media/education campaign. There are four overall strands to the campaign, as recommended by international best practice.[102] ▪ **Motivation**: provides smokers with

[102] Schar and Gutierrez, (November 2001): Smoking Cessation Media Campaigns from Around the World. Recommendations from lessons learned

		to quit smoking and has required a long time to stop (8 months with the current quit attempt). The focus has been on breaking the link between smoking and stress and providing support when there is a need to be calm. Ann is in her early 60s and was diagnosed with schizophrenia in her 20s. She also suffers from diabetes and heart disease. Her physical health problems, including major heart surgery, prompted her to quit several years ago but she found it very difficult to do so. Ann was a heavy smoker, 60 a day. When one cigarette was over she would light another if the situation allowed. All her family and many friends smoke and therefore there was little support in those quarters for her to remain tobacco-free. Support from a cessation service and regular phone calls for reassurance and encouragement, along with continued use of NRT gum and inhalators, has allowed her to remain abstinent for 8 months, her longest quit period. At the beginning of her quit attempt Ann rated her confidence in being able to succeed as 0 out of 10 and has found that her belief in her ability to quit has increased simply by doing it. In the past when Ann has lapsed she would leave the house to smoke without the family being aware that she had started smoking again; she was afraid to admit her failure. She feels that the smoke-free public places law has definitely helped to reduce her exposure to other people's smoking and hence to the pressure to resume smoking. Although Ann has been using an inhalator, she often sucks on the plastic mouth piece when there is no NRT left; it gives a degree of comfort. She has been on NRT for a considerable length of time but feels the benefits outweigh any possible disadvantages and believes that she will eventually quit using this support. She feels proud of her achievement and has been saving a considerable amount of money that has been used to	new and motivating reasons to quit ▪ **Support**: outlines the choice of NHS support available ▪ **Reducing exposure to second-hand smoke**: demonstrating that second-hand smoke is dangerous, not just unpleasant ▪ **Product and Pack**: links the health messages back to the product, giving the smoker another reason to quit. The campaigns, which include advertising, PR and direct marketing, aim to motivate smokers to quit, to highlight the NHS support available to them, as well as to educate the public about the dangers of secondhand smoke. A recent campaign was 'Get Unhooked'. That was followed by the advertising campaign informing people about the smoking ban. The advert shows an 'everyday' man walking through a variety of locations, including a café, pub, garage and office, which will all be required to be smoke-free. The character explains that from 1 July, smoking will no longer be allowed in enclosed and substantially enclosed public places and workplaces. The ad finishes outdoors, in a pub garden, where smoking will be permitted. Recent research carried out among businesses in England showed that

		buy clothes and trips away. In the absence of smoking Ann has recognised that smoking contributed a lot to her anxiety. Now she realises that anxious moments are not because she needs a cigarette, or, that it would help to have one, but that the way she feels happens sometimes and she can use other ways to calm herself, for example, seeking supportfrom her counsellor and friends. **Insights from Ann's story** *Theme 1: NRT* This group of insights focused on the benefits of NRT. It was felt that NRT should be provided for as long as it is needed. Even when nicotine has dried up, an inhalator can sometimes provide a good "prop" or substitute for a cigarette in the mouth. One participant sounded a note of caution, however, about the risk of dependency on nicotine through NRT. Another raised the issue of prescribing of NRT and questioned whether this could be done by smoking cessation advisors rather than GPs. *Theme 2: Confidence* These insights related to the importance of self-confidence in giving up smoking and the impact of smoking on levels of self-confidence and anxiety. Ann's story illustrated that she felt very little self-confidence initially, but her confidence had grown the longer she abstained from smoking. Participants felt that it was important to help people to develop self-confidence and that smoking cessation workers should be taught skills to support and build people's confidence. It was also recognised, from Ann's story, that persistence was important in giving up smoking, as some people need long-term support to maintain abstinence. It was felt that people who are attempting to give up should be helped to understand how difficult it can be and that perseverance and determination are needed. It is also useful to try to learn from relapses, so	41% did not realise that smoking rooms will have to be closed. More than half were unaware that work vehicles will also be covered by the legislation. Public health minister Caroline Flint said: "The campaign is a reminder to people of the date [of the smoking ban] and gives examples of the range of locations which will be smoke-free. It forms part of a comprehensive communications campaign to make sure that businesses and individuals understand what action they need to take." <u>Results</u> According to the government's website, in 2005, advertising continued to be the biggest prompt for people giving up smoking (27%) ahead of 'something said by doctor' (22%) and 'something said by friend or family member' (20%). Campaigns also helped generate nearly 400,000 calls to the NHS Smoking Helpline, and nearly 600,000 visits to the campaign website: www.givingupsmoking.co.uk. It is important to note that the prominence of anti-smoking national media is likely matched by other media campaigns targeting problem health behaviours in Brinnington. A full competition analysis in this respect has not been done here, but

		that support can be tailored in future. *Theme 3: Tailoring services* Three main groups of insights fell under the overall theme of tailoring services to individuals. One group of insights was about the support that is offered to people trying to give up smoking. It was felt that a range of types of support were needed. Group support had not worked for Ann and she had found the one-to-one support most useful. For her, it was lonely trying to quit, and the regular support via phone calls helped enormously. Participants felt that individualised support was an important option, particularly for people with multiple problems. The second group of insights was about the need to listen to the clients' stories, value their experiences and tailor services directly to their needs. It was felt that the standard model of smoking cessation programmes was unlikely to work with people with mental health problems and that the service should be driven by the smoker's needs. The third groups of insights related to the need to provide support for as long as it is needed. In Ann's case, the standard seven-week smoking cessation support programme was insufficient. It was felt that timescales for support should be tailored to the individual's needs as "it takes as long as it takes" to give up smoking. *Theme 4: Stress* This group of insights arising from Ann's story related to stress. Ann said that, for her, it became apparent that smoking was actually causing her stress, rather than relieving it. This was an important step for her in the	social marketing interventions should take into consideration other potential influences over the target market's attention.

		process of giving up. Participants therefore felt that it is important to support and educate people, particularly those with mental health problems, to manage their stress using techniques other than smoking. *Theme 5: The smoking ban* The final insight from Ann's story was that the smoking ban had helped her to give up smoking.	

		The West Sussex Maternal Smoking Public Service Agreement (PSA) Main contact: Hannah Goss Tel: 01903 707426 Email:hannah.goss@aaw.nhs.uk The West Sussex Maternal Smoking Public Service Agreement (PSA) aimed to increase the number of pregnant women who attend smoking cessation clinics and quit smoking in West Sussex between April 2003 and March 2006. Activities: **Branding** A 'Quitting for Two' logo was designed and posters, leaflets and business cards were produced. The aim of the publicity material is to give pregnant smokers and their partners and families positive messages about the support available to help them quit smoking. The material is designed to appeal to women of a variety of ages. The material has been disseminated to a wide range of venues and individuals. **Raising the profile** A West Sussex Maternal Smoking Summit, held in November 2004, and attracted delegates from a broad range of health and non-health professional groups. The keynote speech was delivered by the Deputy Chief Medical Officer which ensured that the summit had a high profile both nationally and locally. Maternal smoking publicity material was also launched at the summit. Regular press releases, radio interviews and opportunistic communications have also ensured that maternal smoking remains high on the local agenda. **Enhancing inter-agency work** Opportunities have been explored for promoting referrals to smoking cessation services from non-health professionals such as social workers. It has been agreed at county level that each Family Centre across West Sussex will identify a referrer for whom training will be provided. The Maternal Smoking Coordinators have met with key individuals across the county to discuss and put actions in place to promote maternal smoking cessation. The West Sussex Maternal Smoking PSA includes three targets relating to the number of pregnant women setting a quit date through smoking cessation services, the number of pregnant women who successfully quit at the 4 week monitoring point and the number of women who have not returned to smoking one year after their quit date. Results Clear progress is being made and more pregnant women have been accessing smoking cessation services across the county than before. The number of pregnant women setting a quit date already far exceeds the number expected without the PSA over the whole three year period (66). At the midpoint of the PSA process (September 2004), 116 pregnant women had set a quit date with smoking cessation ser vices across West Sussex. Twice as many women have already quit smoking at 4 weeks than would have been expected by March 2006 without the PSA. At the midpoint of the PSA process, 54 pregnant women had quit smoking at the 4-week monitoring point. Midwives and some GPs and consultants have received training in maternal smoking which is increasing the number of referrals to smoking cessation ser vices. It is challenging to work across 5 Pacts with very different populations, service capacity and priorities. However, it has also been advantageous to the PSA to have such a wide variety of

		Sheffield cessation intervention for pregnant women[103] The intervention based in Sheffield sought to reach pregnant women and their families in their own surroundings, concentrating on areas especially high in low birth babies. Previously, services to aid pregnant smokers were offered in the maternity hospital. Formal groups were organised but this approach suffered from a lack of response. This led to clinics being cancelled and smoking cessation advice was restricted to brief intervention by health professionals – this brought few successful interventions. Research was carried out in South Yorkshire to find out why women continued to smoke throughout their pregnancies and why they were reluctant to access groups to aid cessation attempts. Reasons included lack of childcare facilities, travel difficulties and often the timing of groups was difficult to fit in with domestic arrangements. In 2001 a full time midwife was appointed to the Sheffield Stop Smoking Service with a view to working towards reducing the number of women who smoked throughout pregnancy. One to one consultation visits were made to clients homes with times to suit families. Referrals are made through midwives, consultants, medical staff, GPs, health Visitors and pharmacies. An introductory letter was sent to all clients, congratulating women on expressing interest in quitting smoking, then asking them to ring the service (free phone number) or contact the specialist midwives directly to make an appointment. Usually the appointment is given for the same week or the following week. Home visits were made weekly for at least five weeks then at regular intervals throughout the pregnancy to maintain cessation up to and beyond the delivery date. Advice on smoking cessation was given,	

[103] http://www.renewal.net/Nav.asp?Category=:health:health%20issues:smoking

		and carbon monoxide monitoring took place - a popular addition which also acted as an incentive for all taking part. Advice on diet, exercise and change of lifestyle was also much a part of the initiative. Partners and family members were also encouraged to use the service, which in turn would help the pregnant women in their efforts. At four weeks, families who had successfully quit smoking were rewarded with a gift of fruit hampers (to encouraging healthy eating). Sheffield also has a voucher system for clients to access free use of leisure facilities at local leisure centres. All Sure Start midwives were trained in smoking cessation and appropriate referrals were passed to them directly. Health visitors were notified of all clients accessing the service and many health visitors were also trained in smoking cessation enabling them to continue to support the women in the post natal period Medical staff, obstetricians and nursing staff at the Sheffield Teaching Hospitals Trust were very supportive and encouraged women to access the service. Sheffield Stop Smoking Service hosted by Sheffield West PCT who support and fund the service. <u>Results</u> More than 200 women have accessed the service, seventy women have stopped smoking at a four week monitoring stage and thirty partners have also quit smoking. For the first two years of the service just one full time midwife was available. Over the last twelve months more than 200 women accessed the service and have been given help and advice on obtaining nicotine replacement therapy to help them to stop smoking. Seventy women had stopped smoking at a four week monitoring stage and thirty partners had also quit smoking. Since January 2004 another full time midwife has been in post, enabling the service to expand and develop.	

		Evaluation An important component of the project's success is that it was based on the identified needs of the pregnant women themselves and these were considered when designing and developing the smoking cessation service. For example, contacts often took place in at home, rather than at a clinic.	
		Acupunction case study in Plymouth[104] Acupuncture and acupressure are used to help smokers, though a systematic review of the evidence of their effectiveness was inconclusive. The aim of this research was to determine the feasibility of a study to test acupressure as an adjunct to one anti-smoking treatment currently offered, and to inform the design of the study. Therefore, an open randomised controlled pilot study was conducted within the six week group programme offered by the Smoking Advice Service in Plymouth, UK. All participants received the usual treatment with NRT and group behavioural therapy, and were randomised into three groups: group A with two auricular acupressure beads, group B with one bead, and group C with no additional therapy. Participants were taught to press the beads when they experienced cravings. Beads were worn in one ear for four weeks, being replaced as necessary. The main outcome measures assessed in the pilot were success at quitting (expired CO ≤ 9 ppm), the dose of NRT used, and the rating of withdrawal symptoms using the Mood and Symptoms Scale. Results From 49 smokers attending four clinics, 24 volunteered to participate, 19 attended at least once after quitting, and seven remained to the final week. Participants who dropped out reported significantly fewer previous quit attempts, but no other significant differences.	

[104] White, AR; Moody, RC and Campbell, JL, (2007). Acupressure for smoking cessation – a pilot study**.** *BMC Complementary and Alternative Medicine*, **7:**8

		Participants reported stimulating the beads as expected during the initial days after quitting, but most soon reduced the frequency of stimulation. The discomfort caused by the beads was minor, and there were no significant side effects. There were technical problems with adhesiveness of the dressing. Reporting of NRT consumption was poor, with much missing data, but reporting of ratings of withdrawal symptom scores was nearly complete. However, these showed no significant changes or differences between groups for any week. <u>Evaluation</u> Any effects of acupressure on smoking withdrawal, as an adjunct to the use of NRT and behavioural intervention, are unlikely to be detectable by the methods used here and further preliminary studies are required before the hypothesis can be tested.	
		<u>Pharmacy cessation provision: Examples of good practice</u>[105] **Manchester:** a primary care trust-funded scheme involves 63 trained pharmacy advisers **Croydon:** community pharmacist Andrew McCoig sits on the steering group of his PCT and is actively involved in its smoking cessation scheme. In the borough there are 22 pharmacies with trained pharmacist advisers. Mr McCoig has helped 355 clients over the past two years and the borough has a four-week quit rate of between 45 and 50 per cent. The scheme is complemented by services run by practice nurses, one doctor and a handful of specialist smoking cessation advisers. **Harrow:** Sally Hone, smoking cessation co-ordinator at Harrow PCT, says that, unlike most other schemes, the	

[105] http://www.pjonline.com/Editorial/20040306/news/news_smokingcessation.html

		Harrow service is mainly pharmacy-based. “We looked at using GP-based schemes including group therapy but this does not allow as many people to go through the service,” she says. The scheme, which now involves 40 trained pharmacist smoking cessation advisers, grew out of a pilot designed by five community pharmacists and which was rolled out in November 2003. Pharmacists in Harrow receive systems training and motivational counselling training in line with national standards. The PCT is also working with nicotine replacement therapy manufacturers to extend its training capability. Harrow pharmacists can supply NRT free of charge to eligible smokers. Harrow uses a patient group direction to allow supply. Patients exempt from prescription charges receive five weeks supply of NRT free of charge. Those who are not exempt pay a one-off prescription charge of £6.30. All clients fill out a pre-assessment form that is sent to the PCT. Their progress is followed and feedback is obtained to evaluate how well the service is received. The scheme boasts a 60 per cent success rate for five-week quitters. At the end of the five-week course, clients are referred back to their GP for further supply of NRT on FP10 if appropriate. **North-East London**: Pharmacists are also providing a co-ordinated smoking cessation service. Hemant Patel, secretary to the local pharmaceutical committee, estimates that between April and December 2003 local pharmacists helped over 2,000 people give up smoking. “Our intention is to ensure that 90 per cent of the smoking cessation capacity is community pharmacy based with an average quit rate around 70 per cent [the four-week quit rate currently stands at 56 per cent].”	

9.2.7 Prevention intervention review

The ISM's systematic review examined 21 studies of interventions for smoking prevention among young people.
· 14 of the 21 comprised school-based programmes
· 5 multi-component community interventions
· 1 media-based programme
· 1 environmental intervention.
· The follow-up period in the studies ranged from one month to 15 years, with the majority following up respondents for 1 to 2 years.
· The majority of the studies which examined short term impact (up to 1 year) reported significant positive effects on prevalence ((13 out of 18 studies)
· The majority of the studies which examined medium term impact (up to 2 years) reported significant positive effects on prevalence (7 out of 11 studies)
· 2 out of 5 studies which examined longer term impact (over 2 years) reported sustained significant positive effects on prevalence.
· 4 interventions had no effect at any period of follow-up.

Results are shown below.

Short term impact

- 18 studies examined *short-term impacts* on smoking prevalence (up to 12 months).
- 13 of these 18 found significant positive effects on prevalence
- 4 found weak or partial effects
- 1 intervention was not effective

Only those with significant positive effects have been listed here.

Control	Design	Support	Educate
			School-based programmes • 3 of the effective school interventions were trials of the **Life Skills Training programme** with different minority ethnic inner city student populations. • 1 found significantly lower frequency of smoking ($p<0.01$) in intervention students compared with control students at 3 months • 2 found significantly lower prevalence in intervention students at 12 months ($p<0.001$ for both) **Project Towards No Tobacco Use**, which compared four different types of social influences and informational curricula, found that most of the curricula were associated with significantly lower increases in experimental and weekly tobacco use compared with control schools at 1 year follow up ($p<0.05$), and that the combined social influences curriculum had significantly lower weekly smoking compared with other curricula and the control group at 2 years ($p<0.05$) A trial of **Project ALERT** followed up over 5 years found, among baseline experimenters, significant reductions in ever, weekly and daily smoking compared with the control group at 3 and 12 months. In a trial of the revised version of **Project ALERT**, involving 55 schools, there were 19% fewer smokers post-intervention compared with controls ($p<0.01$)

			Students who received the **Project SMART** social influences programme had significantly lower smoking onset than control students, equivalent to a 38% reduction, at the end of one year. A 12-session version of **Project Towards No Drug Abuse** found lower monthly smoking at 1-year follow-up for students who received the programme led by a health educator, compared with students who learned it through self-instruction and control group students.
		Multi-component community interventions **Project SixTeen** *(Biglan 2000)* Designed to reduce both illegal sales of tobacco and youth tobacco use, the intervention was associated with lower smoking prevalence (smoking in the past week) at one-year follow-up. **Project STAR** *(Pentz 1989)* The multi-component drug prevention programme Project STAR, or the Midwestern Prevention Project, resulted in a significantly lower increase in smoking in intervention schools compared with controls at one year follow-up. **North Karelia** (Vartiainen 1998) Students who received the youth component of the **North Karelia** project, a major community intervention to reduce cardiovascular disease, had significantly lower once-a-month smoking than the control group at 6-month and subsequent follow-ups. **Minnesota Heart Health 'Class of 89' study** *(Perry 1992)* Students who received a 3-year school-programme within the 5-year Minnesota Heart Health Program, had significantly lower weekly smoking prevalence than control community students at one-year and subsequent follow-ups (see below).	
			Media-based intervention *(Flynn 1994)* The remaining short-term effective programme was a media-based intervention. Students who received mass media smoking prevention television programming combined with a school curriculum had significantly lower weekly smoking (equivalent to 7.3% difference) and smokeless tobacco use at one year follow-up ($p<0.05$) compared with a control group.

Medium-term impact

- 11 studies examined *medium-term* impacts (one to two years) on smoking
- prevalence. 6 of the 11 had significant positive effects
- 1 had weak effects.
- 1 had mixed effects.
- 2 were not effective.

Only those with significant positive effects have been listed here.

Control	Design	Support	Educate
		Multi-component community interventions 4 of the interventions with a significant medium-term impact on smoking were multicomponent community interventions.	

		Project SixTeen *(Biglan 2000)* Designed to reduce both illegal sales of tobacco and youth tobacco use, had a significant effect on smoking prevalence (smoking in the past week) five years after the start of a 3-year intervention ($p<0.05\%$); prevalence was 3.8% lower in the intervention communities compared with communities which had received only a school-based programme	
		Project STAR *(Pentz 1989)* The multi-component drug prevention programme Project STAR, or the Midwestern Prevention Project, resulted in a significantly lower increase in smoking in intervention schools compared with controls at both one and two year follow-ups.	
		North Karelia project *(Vartiainen 1998)* Students who received the youth component of the North Karelia project, a major community intervention to reduce cardiovascular disease, had significantly lower once-a-month smoking than the control group at two-year follow-up and beyond.	
		Minnesota Heart Health 'Class of 89' study *(Perry 1992)* Students who received a 3-year school-programme within the 5-year Minnesota Heart Health Program, had significantly lower weekly smoking prevalence than control community students at 2-year and subsequent follow-ups.	
			Project Towards No Tobacco Use *(Sussman 1993)* Which compared four different types of social influences and informational curricula, found that most of the curricula were associated with significantly lower increases in experimental and weekly tobacco use compared with control schools at 1 year follow up ($p<0.05$), and that the combined social influences curriculum had significantly lower weekly smoking compared with other curricula and the control group at 2 years ($p<0.05$) **Project Towards No Drug Abuse** *(Sussman 2002)* A 12-session version of Project Towards No Drug Abuse found lower monthly smoking at 2-year follow-up for students who received the programme led by a health educator, compared with students who learned it through self-instruction and control group students. **Media-based intervention** *(Flynn 1994)* Students who received mass media smoking prevention television programming combined with a school curriculum had significantly lower weekly smoking (equivalent to 7.3% difference) and smokeless tobacco use at 2 years ($p<0.05$ for all) compared with a control group.

Long-term Impact

- 5 studies followed up participants for more than two years to assess *long-term* impact on smoking prevalence.
- 2 of the 5 found sustained effects
- 3 found no effects over this longer period.

Only those with sustained effects have been included here.

		North Karelia project *(Vartiainen 1998)* Students who received the youth component of the North Karelia project, a major community intervention to reduce cardiovascular disease, had significantly lower once-a-month smoking at 8 years but only for students who had received the teacherled programme. At 15-year follow-up, when participants were aged 28, meantime lifetime consumption was 22% lower in the intervention community compared with the control area (p=0.01).	
			In the 'Class of 89' study *(Perry 1992)* Students who received a 3-year school-programme within the 5-year Minnesota Heart Health Program, had significantly lower weekly smoking prevalence than control community students at all follow-ups up to 5 years ($p<0.04$ – $p<0.0001$).

9.2.8 Conclusion: What works best?

Moher *et al* (2003) found strong evidence that interventions directed towards individual smokers increase the likelihood of quitting smoking. These include advice from a health professional, individual and group counselling and pharmacological treatment to overcome nicotine addiction. Self-help interventions are less effective. There was limited evidence that participation in programs can be increased by competitions and incentives organised by the employer.

Similarly, in her ASH report, McNeill states that:

> Evidence based and professionally endorsed national smoking cessation strategy involving brief opportunistic advice to quit from health professionals, with a prescription for effective pharmacological treatments, backed up by intensive specialist cessation support for those smokers who need it.

11.0 Review of potential stakeholders

The following table is a list of key groups and contacts that are potential stakeholders. Discussions with those shaded grey are detailed below the tables. Those shaded blue were left numerous messages and did not get back in touch within the time frame of this report but are still considered to have potential:

11.1 Health and smoking cessation groups

Grove Medical Centre	Windlass Place, SE8 3QH 020 8692 1882 2 practice nurse advisors - Valerie Pusey and Louise Philpott Senior partner: Dr Akber Mohamedali Practice manager: Anthony Davis Anthony.davis@gp-g85085.nhs.uk	9am-6pm Wed shut 1pm
Kingfisher	Kingfisher Square, Staunton Road, Deptford, SE8 5DA 020 8694 9489/ 020 8691 4142 One practice nurse advisor - Bing Khakwani Senior partner: Dr Ashok Jain Practice manager: Mohammed Khan mohammed.khan2@nhs.net	9am-10.30am, 4.30pm-6.30pm
Waldrum Health Centre (Dr Batra)	Stanley Street, SE8 4BG Dr Batra 020 8691 0144 No nurse advisor Dr Batra has been to GP training. Offers support or gives patients our cards. Practice Manager: Mrs Urmila Batra, Urmila@gp-g85717.nhs.uk	Hours 9am-7pm, Thurs shut 2pm
Waldrum Health Centre (Dr Louise Irvine)	Amersham Vale Training Practice, 10 Amersham Vale, SE14 6DL 020 8692 2314 Practice nurse advisor - Jackie O'Brien Practice manager: Ernie Effemy Ernie.effemey@gp-g85698.nhs.uk	9am-6pm
Waldrum Health Centre (Dr Jamil)	Waldrum Health Centre Stanley Street Deptford SE8 4BG 020 8692 3152 Advisor: Mine Feridun, Counsellor Practice manager: Kamran Syed, Kamran.syed@nhs.net	8.45am – 6.30pm. wed shut 1.30pm.
Clifton Rise	27 Clifton Rise SE14 6ER 020 8692 1387/ 020 8692 1880 1 nurse advisor Senior partner: Dr Kandavel Other GPs: Dr Ajayi and Dr Jeyanathan Practice manager: Uma Jesuthasan uma.jesuthasan@nhs.net	Hours 8.30am-11.304pm-6.30pm
Mornington	433 New Cross Road	Hours 9am - 11.30am,

Surgery	SE14 6TD 020 8692 8299/ 020 8691 0462 Practice nurse advisor: Sandra Franklin, Senior partner: Dr.S.Krishnapalasuryar Practice manager: Dharshika Krishna Dharshika.krishna@gp-g85008.nhs.uk	4 – 6pm
Walk in Centre	New Cross Gate Henderson House Goodwood Road SE14 Practice nurse advisor: Bernadette Kirby 0207 206 3100	Drop in Wednesdays 3-7pm
Pepys Pharmacy	Golden Hind Place Grove St Deptford SE8 3OG 020 8691 3799	- I trained pharmacist level 2, counter staff trained level 1
Lockyer's Pharmacy	252 Evelyn St Deptford SE8 5BZ Ian Schlazer 02086921341	I trained pharmacist level 2, counter staff trained level 1
Nightingale Pharmacy	134 Deptford High street Gita Patel 02086918639	2 pharmacists trained level 2
The Smoker's Clinic	Windsor walk Camberwell SE5 0207 8480054 1 clinic currently runs in Lewisham on Mondays 5.30 to 7pm at Rushey Green Primary Care Centre, Hawstead Rd, SE6 4JN There are 7 or 8 others running at different times and days of the week at the main base at Windsor Walk. Gay Sutherland, Honorary consultant clinical psychologist, Kings College Institute of Psychiatry Gay.Sutherland@iop.kcl.ac.uk	
Community Drug Education Project	Tracey Smithers and Eve Williams are the community drug education worker The Albany Deptford tracey_smithers@hotmail.com mobile: 07990 632546	

11.2 Community organisations

Pepys Community Forum	Lewis Herlitz	lewis@pepyscommunityforum.org.uk 02086943503
Tenants and Residents Association	Maureen Page	Maureen.page@lewisham.gov.uk 020 8314 7263
Deptford Churches	Clodagh O'Reilly-Boyles	0208 692 6548 development@deptfordcc.co.uk
Federation of Refugees from Vietnam	Ahn Tu Nguyen	0208694 0952
Vietnamese Women's	C/o My Tang	trinhmytang@aol.com

Association		
Lewisham Refugee Network	Omolade Oshrenemi Neliswa (Health Trainers Project)	02086940323
African Community Partnership	Aleah Kamruddin	acphealth@btconnect.com 02076359000
Somali Project	Musa Ajama	Musajama2000@yahoo.co.uk
Riverside Youth Club	Joan Barker	07930403798
Evelyn Neighbourhood Management Panel	Gayle Wallace, Neighboorhood Coordinator	Gayle.Wallace@lewisham.gov.uk Extended School house Deptford Green School Amersham Vale New Cross London SE14 6LQ 07725-785717
Deptford Community Forum	Des Malone	02084694248
Lewisham Community Development Partnership	Amanda Gosling (retiring end June 07). Lai See Chew (starts September) Nina Louise Gosling (level 2 trained advisor – on maternity leave end of July)	Brownhill Rd Catford SE6 0208 695 8270
Voluntary Action Lewisham	Miriam Long, Health and Social Care Forum Project Officer.	02086986034 Miriam@valewisham.org.uk
Deptford Green School	Mark Simons, secretary of Deptford Community Forum Claudia Reid is a school counsellor and offers stop smoking advice.	Mark - 02084694248 Claudia - 07908 317 653 e-mail: Claudiareid06@yahoo.co.uk
QUIT	Rebecca Algar (was the assistant on the Somali project previously) Alison Hooper, the facilitator for the Lewisham service is liaising with them re work with young people	QUIT, Old Street, London EC1V 9NR 020 7553 3269 020 7251 1661 r.algar@quit.org.uk
Town Centre Manager	Jennifer Taylor	0208 691 8725
FORVIL	Nga Ndio Federation of Older Refugees from Vietnam in Lewisham.	0208 694 0952
Deptford Indo-Chinese Centre	No contact details	
Deptford Vietnamese Project	My Tang Lind Clinic (Younger client base than FORVIL)	Grove St SE8 3QF 0208 692 8830
Positive Place	David Dore Volunteer co-ordinator: Rebecca Peates Volunteer advisors: Colin O'Neill and Michael Knight	52 Deptford Broadway Deptford SE8 4PH 0208 694 9988
Wavelengths	Ann O'Connor, General Manager	020 86941134
Community Opportunities Service	Arnie Andrews and Beverley Smith are both trained level 2 advisors.	Watson Street Deptford SE8 020 8694 6519

Lewisham Council Community Sector	Sandra Jones	sandra.jones@lewisham.gov.uk 02083146000
Youth coalition	Katie Brown, Area Youth Manager Glen Shepherd (f), Area Youth Manager (new)	
Lewisham Community Network	Brian Waganbak	brian@valewisham.org
London and Quadrant	Sonia Meggie	
Milton Court Estate	Sharon Harvey and Andy Thomas	02083146386
Childrens Centres	Angela Peart	
Hyde Housing Association	Cassandra Savager, Regeneration Coordinator.	02082977572
Clyde Street Early Years Centre	Dave Westmore	02086923653
190 Advice Centre	Elona Elliot	02086917180
Antisocial Behaviour Prevention	Francis Clarke	02083146000
Waldrum Centre Project Manager	Mike Nelson	mike.nelson@lewishampct.nhs.uk
John Evelyn Public House	Doug Elsley (Landlord)	
2000 Community Action Centre	Conroy St. Hilaire (Manager)	02086922760
Evelyn Childhood Centre (Surestart)		
REETA	Linda Nash	07909542790

11.3 Discussions

The following discussion details conversations with key contacts of some of these groups, including ways they may be able to become involved with a future social marketing project:

11.3.1 Clifton Rise

Discussion

It was impossible to speak to a GP but the nurse explained that she made referrals to the Smoker's Clinic in Camberwell or to the GPs for prescriptions. She did not run smoking cessation advice sessions herself. She could not be certain the practice would want to be involved any further without speaking to a GP.

11.3.2 Mornington Surgery

Background

Sandra Franklin does smoking cessation at Mornington. They have very few African-Caribbean smokers – have only ever had one and he did not successfully quit. Most

clients are white. Sandra always asks client's smoking status, particularly when they have COPD, asthma or diabetes etc.

Discussion
Sandra's main comment is that African-Caribbean people are unwilling to keep appointments. They maybe turn up for 2 or 3 sessions then never come back. She has been offered funding from a drug company to write to follow up these lapses and plans to start doing so.

Sandra is happy to be involved with a future intervention. She is slightly concerned that the ban will bring an influx of new quitters and that there will not be time to see them all. She is the only smoking cessation advisor. She believes that more advertising should be commissioned to make people more aware of the dangers of smoking. She believes that shock tactics should be employed with young people to prevent them from starting to smoke.

11.3.3 African Community Partnership: Building Healthier Communities
Background
The organization supports New Cross residents in health, employment and welfare issues. 60% of their clients are non-African. Most of their clients are people who will not or can not access GPs or 'normal' health care workers. Some clients are uncomfortable talking to GPs or feel unwelcome or will only talk about their health to someone they know

They are only funded to work with New Cross residents but do spread their net wider. In terms of smoking cessation they offer 1 to 1 support and run information stalls in the area when the opportunity arises. Aleah claimed that her clients are often 'hard cases'. She has had 4 clients to date but sees 3 or 4 new clients a week for other requirements.

The African population comprises mainly Somali, Nigerian and Kenyan people. The people that the ACP sees are normally fairly recent immigrants, either economic refugees or asylum seekers. Therefore the issues of employment are particularly prevalent. Often qualifications are not transferable to the UK.

Discussion
Aleah stated that the organization is under-resourced and under-funded. She works closely with Lyn Burton and Lyn is aware of this. Aleah is expecting and hoping for an increase in uptake of smoking cessation services after the ban, particularly in winter when smoking outside is no longer a comfortable option. In her experience most smokers want to give up but have more pressing issues. The ban, she hopes, will bump quitting up their priority list.

Aleah was keen to be kept in the loop with possible future interventions.

11.3.4 Jennifer Taylor: Town Centre Manager
Jennifer Taylor is the town centre manager. Jennifer runs the Deptford Festival and the PCT ran a SS stall there since last summer and asked for her support to run No Smoking Day stall in March**.** Jennifer would be interested in getting involved if it were

appropriate. Jennifer mentioned that Tesco's have been involved in providing posters for the pubs in Evelyn trying to stop people littering with cigarette butts.

11.3.5 Clyde Street Early Years Centre

Background

The CSEYC is a Childrens Centre (since 2004) and is LEA funded. There are 40 staff (of whom 3 smoke) and 145 children and babies from 0 – 4yrs. There are parent and toddler groups Monday – Thursday 9.30-11.30 which around 20 adults attend each day. Roughly 200 adults pass through the doors each week and the ethnic mix is representative of the local population. Formerly, 80% of families were African but that is now 50-60%, 20-30% Caribbean and some others with a handful of Vietnamese and Chinese and a few Asian and white working class. There are 3 or 4 middle class families using the center. Although principally women who bring their children to the center, there are some dads as well. The users of the center often rely on it because both partners work full time.

Discussion

Dave Westmore is very keen to help. There are training rooms which can be booked and promotional displays normally get a lot of attention. Although he does not know how many parents smoke, he is keen to get involved if possible. The center already runs computer courses and courses teaching parents how best to teach their young children to learn. There is a culture of improvement at the center. They have run E-SOL courses (English for speakers of another language) in the past.

11.3.6 Kingfisher

Background

Bing Khakwani offers one-to-one cessation advice as part of her normal chronic disease clinic. She does not think the service is very successful. Many people come because they are referred by a GP and then leave after one or two visits. She sometimes follows them up but she is busy with he other patients so does not always have time. Mostly the smokers who have lapsed refuse to talk about why they have lapsed.

Bing commented that she never has Vietnamese men visiting her clinic and that Vietnamese women do not smoke.

Discussion

Bing does not think it would be possible for her to become involved with any future intervention because her clinic is always full and there is no extra time to deal with smokers who would like to give up.

11.3.7 Community Opportunities Service

Background

COS is a center for people with mental health difficulties, offering social activities, counseling and support as well as help getting back to work or returning to normal community life. All attendees are GP or CMHT referred.

Discussion

Beverly and Arnie are both level 2 advisors. They started a group for individuals wishing to give up. The group was intended to be a forum for discussion reasons for

smoking, how and when they started and why they want to give up. Individual sessions were then offered for those wishing to set a quit date. The group did not attract significant numbers of people so mostly the sessions were immediately one-to-one. Currently there are no quitters at all.

COS advertises its cessation service by distributing posters to the CMHT, the hospital, other mental health centers and by promoting the service on its website and in its magazine.

11.3.8 190 Advice Centre

Background

The 190 offers advice on housing, employment, debt and welfare issues to anyone in Lewisham borough.

Discussion

Housing Advisor Dave Watts explained that smoking is only ever discussed with clients in the context of debt. Advisors encourage smoking cessation when expenditure is seriously financially damaging. He felt that referral to smoking cessation services or offering further persuasion to quit would be overstepping the mark in terms of their role.

11.3.9 The Waldrum Medical Centre

Background

There are 3 GPs at The Waldrum and they are about to move into a new building at the end of July/early August. Each deals with smoking cessation individually. There are no group sessions at present.

Discussion with Mrs Batra, practice manager for Dr Batra.

There are plans to introduce a specific smoking cessation clinic after the move to the new building. At present all referrals are made by the nurse or GP. Dr Batra has had level 2 training. All smoking cessation sessions are held between surgeries. There is no set-aside time at present. They always ask the smoking status of patients.

Discussion with Jackie O'Brien, nurse advisor for Dr Louise Irvine

Jackie is concerned that the move to the new Waldrum Health Centre (scheduled for 20th July) will be too time consuming to get involved with an intervention. Reassured that the timescale was longer term, she agreed she would be interested in getting involved. Currently she is seeing up to 4 smokers a day for cessation treatment, although this is largely due to 'panicking' about the ban. She gets a steady trickle of patients and has had moderately good results. Of particular note is the fact that she has recently had more young people attending for smoking cessation advice.

Her main concern is trying to get the asthmatic smokers and those with COPD to stop. She says she has to really 'badger' them into seeking help for cessation. Most, she said, do just walk in of their own accord however.

Discussion with Dr Irvine

Dr Irvine is keen that the new Waldrum Centre is made the best possible use of. There will be plenty of additional space which can be rented to community organizations for a low rent and she is keen to use the Evelyn Neighbourhood

Forum as a steering committee to make sure this is done with best possible impact on the local community.

In terms of targeting an intervention, Dr Irvine feels that focus should be made on young people, children, babies and expectant mothers. Evelyn has disproportionately high numbers of children and young people and high premature birth rates and child mortality. There are also low breast feeding rates.

Dr Irvine commented that Vietnamese new mothers do not breast feed and buy tinned baby food rather than making their own. She feels this is a cause of ill health throughout the life of the child. Dr Irvine would like to see a family approach targeting families together. Dr Irvine is involved with practice-based commissioning in Evelyn.

Dr Irvine's surgery would be key to getting involved with an intervention.

11.3.10 Nightingale Pharmacy

Discussion

A representative of the pharmacy (who does not wish to be named in this report) explained that the majority of their clients are female and have been smoking from a very young age, normally starting at school from peer pressure. Often their clients are unemployed and stressed due to financial or other reasons.

11.3.11 Lockyer's Pharmacy

Background

Ian Schlazer is the well established pharmacist. Ian is proactive and friendly and asks most customers whether they smoke, offering help to quit. The most committed quitters, however, come in off their own back and seek help. Anecdotally, his success rate is 50-60%. Whether or not his clients lapse he will follow them up and encourage them to recommend him to their friends.

Discussion

By far his largest client group is white women with children, who seek help so they do not harm their children. He finds that smoking is particularly prevalent in the Vietnamese population, who tend to believe in fate when it comes to their health, putting ill health down to luck. This applies to both men and women. In addition, the Vietnamese tend to have the poorest English.

Ian's experience is that local residents find the pharmacist more approachable and less intimidating that their GP. No appointment is necessary and people seem to like being able to walk in off the street.

11.3.12 The Grove Medical Centre

Background

The Grove has a strong background of smoking cessation advice. The GPs always ask smoking status and are active at providing cessation advice or referrals. There are one-to-one sessions provided by Valerie Pusey and Louise Philpotts. Both Valerie and Louise see 1 or 2 new people per week. There is no particular pattern to clients in terms of age or gender but Valerie commented on the lack of people with BME backgrounds. Their service is advertised with posters, usually relying on the central advertising by Lewisham PCT.

Discussion
Valerie would like to see a more joined up service to prevent relapses. She often sees and succeeds with smokers who are unemployed and often suffer from other illnesses and mental health difficulties. They may succeed at quitting, she says, but are still left unemployed with other stresses and difficulties. This often causes relapse and reenrollment in cycles.

Valerie finds that her clients are most successful when they decide to give up themselves rather than when they have been instructed to give up by a cessation advisor or GP for health reasons. She is interested in being involved in the future.

11.3.13 Tenants and Residents Associations

Background
There are currently 13 tenants and residents associations in the area but more may be imminent. In order to contact them, a letter of introduction should be addressed 'Dear Chair' and sent to Maureen Page (or her assistant Abena Adjepong). Speakers can attend residents meetings with prior agreement.

Current associations are as follows:

- Bembridge House Tenants and Residents Association (Pepys Estate)
- Colonnade and The Terrace Tenants and Residents Association (CATRA) (Pepys Estate)
- Crossfield Tenants and Residents Association (Crossfields Estate)
- Daubeney Tower Tenants and Residents Association (Pepys Estate)
- Deptford Wharf Tenants and Residents Association
- Eddistone Tower Tenants and Residents Association (Pepys Estate, contact Jane Harmer, 02086925974). The group is new.
- Evelyn Tenants and Residents Association (contact Kevin Harris, kevinharris147@hotmail.com)
- Fiveways Cooperative (Woodpecker)
- Foreshore United Neighbours
- Princess Louise Tenants and Residents Association
- Sayers Court Tenants and Residents Association
- Tanners Hill Tenants and Residents Association
- Trinity Estate Tenants and Residents Association

11.3.14 Deptford Community Forum

Background
Des Malone is Deputy Head of Deptford Green School and Chair of Deptford Community Forum. Des Malone suggested that there are 2 key community groups that should be engaged with any potential social marketing intervention:

- Deptford Community Forum is an umbrella organisation with 300 members (groups) active in the area. The DCF is a good mechanism for accessing potential stakeholders because it is their clients who will be the intervention's target audience. The next meeting of the full forum (which 30 key players attend) on Tuesday 17th July 2007 6pm. Karen Bulsara will attend.
- The Evelyn Neighbourhood Management Panel (see below).

Discussion

Des Malone said that innovative measures are required to engage with people in the Deptford/Evelyn area. He said "People won't come to meetings. You have to do it in a Deptfordy way". He listed previously successful campaigns:

- 'Burger Bar' employment trailer. The trailer was taken around the estates and roused interest by passers by who were engaged in discussions about employment and getting back to work.
- 'Marketing Stall' at the popular Deptford Market. Des explained that "Everyone goes to Deptford Market" so a stall there would rouse interest.

Des suggested piggybacking on meetings which are already successful. He is Deputy Head of Deptford Green School and suggested that a stall at a parents evening would rouse interest. 90% of a year group's parents attend, equalling roughly 220 parents between 4 and 7.30pm.

Des also pointed out that there are 2 permanent venues in the area which may be useful for events or launches:

a. Deptford Green's extended school, in which Gayle Wallace works and where Claudia Reid is based as a permanent smoking cessation advisor for the pupils.
b. Moonshot is the new community centre which was opened on Friday 8th June by the Mayor. There are 3 partners for this new centre:

- IRIE Dance Company (black dance company)
- Playhouse Nursery
- Deptford Green School.
  The centre opens onto the park and there are rooms available for hire. The temporary manager is called Romi (pronounced Rome – ee).

11.3.15 The Evelyn Neighbourhood Management Panel

Background

The ENMP is a key organisation to speak with to engage for a possible social marketing intervention. Their members are a combination of statutory and voluntary groups, eg. The Town Centre Manager. Gayle Wallace is the chair.

Discussion

Gayle Wallace recommended engaging stakeholders at both the next Neighbourhood Management Panel meeting or at the Healthy Big Breakfast on 3rd July at 9am at Deptford Community Church. GPs such as Louise Irvine attend alongside representatives of the PCT and other health workers.

The meeting on 20th June at 4pm (at Deptford Green School) was informative. Present were
Jim Mallory (Chair)
Gayle Wallace
Jane Miller
Cassandra Savager
Kevin Harris (Evelyn Tenants and Residents Association)
2 PCs
2 PCSOs
Louise Irvine
Lewis Herlitz

Brian Waganbak
Des Malone

The panel have a health subcommittee which will be convened to direct the use of the new Waldrum Health Centre as well as discuss practice based commissioning opportunities and other health matters. This would be an ideal committee to get involved with steering the social marketing intervention. The combined knowledge and experience of the committee members will be extremely useful.

The meeting also highlighted the potential of the Health Consortium (GPs) which meets regularly. The next meeting is 13th July. This would be an ideal opportunity to discuss any potential intervention with GPs if this is appropriate.

11.3.16 Lewisham Community Development Partnership

Background

LCDP has a Community Development Model working to improve health and access to information about health for Lewisham residents. They run various groups including reminiscence groups for older people, a youth club, play schemes promoting intergenerational communication, patient and public involvement work, and support for patient panels. Lyn Burton has discussed the possibility of their working with the few GP practices with no nurse advisor: to contact all patients with positive smoking status and invite them to a group based at the practice, or for one to one advice. Amanda Gosling is very positive about this but is unfortunately leaving at the end of June.

Discussion

Amanda Gosling will retire at the end of June 2007. She has commented in the past that smokers have asked for a dedicated stop smoking clinic at The Waldrum Health centre but that they were 'always' told to go to another practice (Jenner) which is a difficult journey by public transport. Dr Batra is planning to get a clinic off the ground in the Autumn.

Amanda believes that smokers need a service nearby with easy access but that there is a fine line to be drawn between offering services too easily and then not receiving such dedicated commitment from the smoker. She suggested some sort of a contract to encourage smokers to think carefully about quitting and commit seriously to quitting. She believes that it may be too easy to start the quit process and give up because the services are always available for the next time.

Amanda suggested that Vietnamese and Chinese men are an at-risk group along with white working class men and women and young Asian men. She believes that although information for youth should be made available (focusing on the cost of cigarettes rather than health risks), the focus of interventions should still be older people because young people are likely to try smoking no matter what information they are provided with. This is particularly the case when family members smoke around children as they grow up.

Although Amanda will not be around after the end of June she suggested that the LCDP would be interested in supporting any intervention that is put forward.

11.3.17 Deptford Green School

Background

Lyn Burton ran a stop smoking stall at the school in summer 2006 at an evening event aimed at raising awareness and signposting to local services. Lyn Burton met Claudia Reid recently. She is interested in working with us, has run groups in the school, has offered information/ education sessions in feeder primary schools and thinks there should be more prevention interventions. Claudia has already done stop smoking training but will join the group going on the one day QUIT training at to network. Claudia did not return any of the calls left for her.

11.3.18 QUIT

Background

QUIT is running a one day training in Lewisham for 16 interested advisors who work with young people and is planning to work with 6 schools.

11.3.19 Somali group

Background

Previous attempts to develop stop smoking work with the Somali community did not succeed. Level 1 training was provided by the previous co-ordinator and then Claire Goldie, a sessional advisor to two different groups of interested Somali people who use SEDEC. Some feedback of the course is given:

- The course has enabled me to explain better the effect of smoking but I am not sure about being able to stop men from smoking[106]
- I feel that the difficulty of people in Somali community accepting stop smoking advice is not whether the advisor is a man or woman - it depends on how it is presented[107]
- I learnt something new about passive smoking especially about the number of people it kills
- I discussed with others the problem in the Somali community about difficulty of people stopping smoking, especially things like loneliness and frustration which make it difficult.

Though the training went well it was felt that it would have been better if the reading material provided were also in their language as a request was made for translation of materials.

Everyone who was asked after this training wanted to go straight on to the level 2 training. Lyn Burton suggested that one or two advisors should be trained at level 2 to begin with but none of the organisers who were asked to do this did so. The full report reads "It is unclear why a trial with the sessional advisor failed. One possible reason that the Somali translator gave was that by introducing someone from outside the community the approach of the initiative of working through the community as had originally been presented had changed without adequate negotiation with the volunteers. Regarding the additional training for the two volunteers, there was a gap in the availability of the next Level 2 Stop Smoking training. By the time training became available the volunteers that had expressed

[106] This was a comment from a female participant

[107] This was a comment from a male participant

interest had moved on, one to paid employment." The report also comments that "there is the need to train up to a more advanced stage (Level 2) Stop Smoking Advisor who are speakers of other language, such as Somali."

Lewisham PCT then asked Quit to help facilitate this project. They wrote a proposal to use some dedicated funding before the end of the year. There was no time to put this into practice before year end so we suggested starting again at the beginning of the next year. They then wrote a full year proposal for the following year which was so expensive and ambitious it was not viable.

A few community workers commented that there are far more women and children in the Somali community than men and that smoking is not a significant problem.

There is also an organisation called SEDEC (Somali Education and Development in the Evelyn Community) which does training events and public information. This is managed by Abdulla Hi (pronounced Hee), who also manages REETA.

11.3.20 The Vietnamese community

Federation of refugees from Vietnam

The organization tends to work mainly with older Vietnamese people who claim their only pleasure is smoking and that they are too old to give up. They have run smoking cessation programmes from which 2 people successfully quitted, one in their 70s.

Dr Louise Irvine has spoken to this group and found great difficulty in getting any to admit to smoking. All claimed to be non-smokers and to know noone amongst their family of friends who smoked. This suggests some cultural barriers to either discussing smoking in general or to discussing smoking in mixed gender company or with a GP.

The Federation would be happy to have someone come and give a talk. The language barrier is clearly a significant problem when communicating with this group.

FORVIL

Background

A health worker based at FORVIL, Kim Quyen Pham, did level 2 training and said she had helped one or two people to stop smoking. Unfortunately she did not return any data and then left. Lyn Burton has been twice to give translated talks to this community group about smoking. The last time, she was told that none of the people who politely listened smoked any more. The only smoker did not to stay to listen.

Discussion

Nga Ndio at FORVIL explained that they have no staff who smoke and that the organisation provides health advise and support for older Vietnamese people, often whose English is poor. She suggested that smoking is a problem but that it is mainly among the younger Vietnamese. She suggested that there are people trying to give up but they tend to do it on their own. She cited language as the main reason for this – people feel reluctant approaching their GP or pharmacist because of the language barrier.

Nga also commented that the Vietnamese community are largely unaware of the forthcoming smoking ban and that a talk from the PCT would be welcomed on this topic. They have luncheon clubs from 10.30 – 12 every Thursday and Friday and this would be a good opportunity to access their members.

Deptford Vietnamese Project

Background

My Tang of the Deptford Vietnamese Project is in touch with a younger group of Vietnamese than FORVIL represents but Lyn Burton has not followed up contact with her.

Discussion

Phung at the DVP is very keen to become involved with any potential social marketing intervention targeting Vietnamese men. She explained that

- Vietnamese men do not want to give up because smoking is an integral part of culturally-defined masculinity for Vietnamese men.
- Children put pressure on their fathers to quit because they learn the facts at school. Recently a child of 9 saw a no smoking sign in Phung's office and asked if he could have one for home to stop his Dad from smoking.
- There are considerable language barriers which prevent Vietnamese men from visiting their GP unless it is for chronic ill health.
- There is an assumption that GPs are for ill health only and not prevention.
- There is not enough information on the impact of smoking to the smoker and those around them targeted to the Vietnamese community. It was felt that not enough of the health facts filter through because of the language barrier. It is thought that information on the impact of passive smoking to children and family would be impactful.

Phung would be happy to host a clinic at the DVP (they already have health meetings at irregular intervals) or to refer to other services geared up specifically to Vietnamese people.

Eve Williams at the Community Drug Education Project commented that there used to be a refugee health clinic at the Ladywell which included smoking cessation but that this has now closed. She has worked with the Vietnamese community and comments that there is a great need for a similar drop in centre for the Vietnamese community because GP referrals for smoking cessation are unsuccessful due to an unwillingness to visit them.

11.3.21 Positive Place

Background

An organisation for HIV positive people, has another model of providing stop smoking advice. Lyn Burton was asked by David Dore to go to a launch of their smokefree policy in July 2005 and provide stop smoking advice at the Place. Consequently the organisation trained some of their volunteers at level 2. They offer support and give vouchers for people to take to one of the local pharmacies to exchange for NRT.

11.3.22 Wavelengths

Background
This is a big Leisure Centre in Deptford run by Parkview Leisure. Ian Thompson, Development Manager for Parkview has now left but was a trained level 2 advisor but is based at The Bridge in Sydenham. He arranged for his staff to have level 2 training. Only 5 came and most were smokers who did not want to stop, or not immediately anyway.

11.3.23 Pregnancy and smoking

Background
Claire Goldie has gone to many of the booking in clinics and responds to midwife referrals. The Sure Starts have now been superseded by Children's Centres. Lyn Burton is planning to meet with head of midwifery and area managers for children's centres to redesign support to pregnant women and families as it is not working well at the moment.

11.3.24 Community Drug Education Project

Background
Eve and Tracey work from a rented unit at The Albany just off Deptford High Street. Eve particularly is involved in outreach and goes to schools and works on different estates educating young people about drugs.

Discussion
They already do some level 1 work with smoking cessation, pointing people in the direction of The Walk In Centre. They have leaflets which they hand out and talk to young people when the subject arises. They would be happy to get involved and offer advice for an intervention.

11.3.25 Riverside Youth Club

Background
The youth club is on Grove Street in the middle of the Pepys Estate. It has a football court area and offers steel band, cooking, computer sessions and sports. There is also a Milton Court Estate youth club.

Anecdotally Joan claimed that few young people using the Riverside Youth Club smoke. The 17 year olds and over smoke cannabis but cigarettes are not such a problem. She admitted that this was not necessarily representative of behaviour amongst young people in the rest of the ward.

Discussion
Joan is extremely keen to help with any intervention. She does smoke herself, along with 6 or so of her staff. She would be interested in facilitating a cessation program for the youth club and going along herself to quit. She has lots of space at the club and we could use it for a clinic or group session.

11.3.26 John Evelyn Public House

Background
The John Evelyn is on the corner of Grove Street and Evelyn Street and has large windows filled with posters advertising the Tour de France (which starts in London), various community events and the smoking ban. Doug Elsley is throwing a smoking

party on 30th June for which he is providing the cigarettes and where he will invite customers to take home his ashtrays as a momento.

Discussion
Doug is against the ban on principle, believing it to be against civil liberties. He does not smoke himself. He conducted a survey of staff and customers and found that 95% of customers smoke and 100% of staff. He is expecting his food trade to go 'through the roof' and is having his wine list and décor revamped in anticipation.

He has offered to pay for his staff to have NRT patches if they give up. He will not be offering them smoking breaks (they used to smoke whilst collecting glasses). His staff are not keen. He would be happy to get involved with a cessation program for customers as well if he were given the suitable materials.

11.3.27 Dr Hashmi
Dr Hashmi's branch practice is on Evelyn Street next to Sure Start, although she is a GP for Greenwich area. She does some smoking cessation advice and is interested in being kept in the loop. I spoke to head receptionist Ita Hill.

11.3.28 2000 Community Action Centre
Background
The CAC is a large echoey building on the Pepys Estate next to the Riverside Youth Club. They run karate, line dancing and aerobics as well as having an internet café and diabetes club sessions. Currently the internet café is not open due to internal political and funding issues.

11.3.29 Police Initiatives
The police and police community support officers in Evelyn and New Cross run diversionary iniatives during the summer for young people. This summer this will include a climbing wall at the Riverside Youth Centre. Young people will need to sign up to a code of conduct (the Riverside Youth Centre's behaviour code) and then can use the wall. Other initiatives include a gardening scheme which is currently seeking resource and a boxing scheme for 10-16 year olds teaching them to respect their bodies and embrace discipline.

11.3.30 Pepys Community Forum
Background
Lewis Herltiz runs the PCF, based near the scrap yard on Grove Street. The forum represents the Pepys Estate only. The PCF has 2 main organisational interests, the recycling project and the refugee employment project.

Discussion
The PCF would be supportive of any initiative or intervention run to target smoking cessation. Lewis Herlitz is a key community figure. Their Refugee Employment project (REETA, see below) employs 6 members of staff and aims to get refugees into work through training, language training, and bureaucracy guidance (such as hand holding through the job centre process). Training is outsourced.

Lewis ran a mentoring pilot that was successful for 5 or 6 individuals who reportedly made positive change to their lives. This does not run any more.

The recycling project is one of 3 London wide. Waste is collected from the estate (garden and kitchen) and processed in the warehouse next to the PCF. Currently they are awaiting certification that the resulting compost can be sold. They employ an outreach worker (for the next 4-6 weeks) who goes door-to-door encouraging recycling and reminding current recyclers and distributing the materials to recycle. Half the Pepys Estate residents are currently signed up.

11.3.31 REETA (Refugee Employment and Education Training Association)

Discussion

This is managed by Abdulla Hi (pronounced Hee) and is based at the 2000 Community Action Centre and is involved with getting refugees back to work and accessing language and skills training and other resources such as the job centre.

Linda explained that smoking is not such a problem in the Somali community (although chewing is) and that the Vietnamese community is difficult to infiltrate. She reinforced previous knowledge by saying that smoking is part of Vietnamese culture for men, along with drinking and gambling.

Discussion

As of 30th June there will be 6 members of staff (there are currently more). Linda Nash is one of those leaving. She recommends being in touch with Alex Hopkins who is a second generation Vietnamese older man who speaks Vietnamese and English. He does community drugs work. There is also a Vietnamese worker called Minh Phal who does 10 hours a week. She will be in touch with their telephone numbers.

In principle, REETA would be happy to get involved with a future intervention.

11.3.32 Lewisham Refugee Network

Lewisham Refugee Network run a Health Trainer's Project to disseminate information on hypertension, diabetes, healthy eating, mental and physical wellbeing and stopping smoking. They were consistently unavailable to talk to but could potentially be a way of reaching hard to reach groups. Health trainers run a session at the 2000 Community Action Centre every Wednesday between 12.30 and 3pm.

11.3.33 Walk in Centre

Background

The walk in clinic is in Camberwell and joint funded by 3 different PCTs, including Lewisham. Lewisham are due to withdraw their funding at Christmas (having given notice last Christmas) because the service is too far away from Lewisham residents. It is noted, though, that the Community Drug Education Project still refer people to the centre. The walk in clinic is currently at Lewisham Hospital. It treats 'hard core' smokers in the main.

Discussion

Gay Sutherland commented that she is happy to bring the service closer to Evelyn residents but that finding suitable accommodation for the service has always been problematic. The possibility of using space in the new Waldrum Medical Centre was

briefly touched on. She runs groups and therefore often requires space for 25-30 chairs.

11.3.34 North Downham Training Project: Discussion for background information

Background

The project is a voluntary organisation providing training for back-to-work. Penny Morioka has incorporated a smoking cessation service as part of her offering. Her service is funded for 2 years from this year by Local Public Service Agreement funding but has been running unfounded for several years. The training centre has been in existence for 21 years and Penny Morioka (then the manager) noticed that many students were smoking. From concerns for their health and also the financial strain on them and their families through smoking, Penny started a stop smoking group. This came to a natural end when there were fewer smokers. When the numbers of smokers starting to rise again her interest in restarting the group coincided with PCT training and she is now a level 2 trained provider. She has run 2 8 week sessions and is about to start a third. She also sees people individually and in pairs or families if they request it.

Penny Morioka - tel: 0208 698 7436, pmorioka@northdownhamtraining.co.uk.

Discussion

- The combination of NRT with group support works well and is effective
- Flexibility is key to a successful service. Penny will conduct one-to-one sessions as well as family sessions or pairs. Her preferred method of working is groups.
- Understanding the individual motivations of the quitters is vital. For example women may worry about weight gain in some cultures but weight loss in others, where being bigger is associated with success and wealth.
- Most of her clients are unemployed women with children
- The few men she has seen have been pressured by their children or wives to stop smoking.

11.3.35 Voluntary Action Lewisham

Miriam Long runs a forum for voluntary organisations in the Health and Social Care field in Lewisham. The forum meets once a month to discuss issues to do with health and social care. There are refugee groups, carers groups and others. They also organise training sessions. There is an email list which might be of use.

Discussion

Miriam is happy to offer the services of VAL. She is based at St Lawrence Community Centre, Catford. Brian Waganbak is based in Deptford. Miriam would target a prevention intervention at young people given the choice.

Of importance is the small grant that VAL has to provide a worker to a group who has an interest in providing a smoking cessation service to their members. Their experience is that uptake has been poor (no uptake so far). Their worker is level 3 trained and called Elaine Osborne. This resource could potentially be useful.

11.3.36 Other potentially useful stakeholders

- **Deptford Market** is busy and popular. When I visited there was a stall for SKY television. It may be possible to run a stop smoking information stall there. It is very near The Albany.
- **The Albany Theatre** has a large café and meeting rooms. The units which are street-facing are rented to community organisations (such as the Community Drugs Education Project) and offices. The café and building are modern and 'trendy' with music playing and good food served. The café has flat screen wall-mounted television screens which advertise the theatre shows. There is an outside patio area. The Albany is a short walk from Deptford Green school. The café area is pictured below:

Contact Senay Gaul (pronounced Shen-eye) on 02086920231 or emailo senay.gaul@thealbany.org.uk.

- **Dentists**

There are at least 2 dentist practices in the Evelyn area which could be a useful base for data and for running an intervention.

- **Hairdressers and nail technicians**

The sociable nature of hairdressers and nail technicians could be a potentially powerful way of providing brief interventions to their smoking clients.

- **There is a Deptford Churches Centre for drinkers.**

11.4 Summary

It is important to have support from local well established groups when instigating a social marketing initiative. The following table summarises support which these conversations have suggested is available:

Full support offered	
Sandra Franklin	Mornington Surgery
Jennifer Taylor	Town Centre Manager
Dave Westmore	Clyde Street Early Years Centre
Ian Schlazer	Lockyer's Pharmacy
Valerie Pusey	Grove Medical Centre
Des Malone	Deptford Community Forum

Gayle Wallace	Lewisham Neighbourhood Panel
Rebecca Algar	QUIT
Amanda Gosling (replacement)	Lewisham Community Development Partnership
Dr Louise Irvine/ Jackie O'Brien	The Waldrum
Eve Williams and Tracey Smithers	Community Drug Education Project
Doug Elsley	John Evelyn Public House
Joan Barker	Riverside Youth Club
Linda Nash	REETA
Miriam Long	Voluntary Action Lewisham

Possible support: 'keep in the loop'	
Aleah Kamruddin	Building Healthier Communities
Arnie Andrews and Beverley Smith	Community Opportunities Service

Interest which could be developed	
-	Federation of Refugees from Vietnam
Dr and Mrs Batra	Waldrum Medical Centre
Nga Ndio	FORVIL
My Tang/Phung	Deptford Vietnamese Project
	Clifton Rise
Dr Hashmi	Dr Hasmi (GP)

Not interested at this stage	
Bing Khakwani	Kingfisher Medical Practice
Dave Watts	190 Advice Centre

Possible support but not able to get in touch	
Claudia Reid and Mark Simons	Deptford Green School
Ann O'Connor	Wavelengths
Conroy St. Hilaire	2000 Community Action Centre
	Evelyn Childhood Centre
Dental practices (Evelyn Street and Deptford High Street)	
Churches	
Mosque	

12.0 Initial segmentation

Segmentation is vital for the success of a social marketing intervention and is one of the NSMC's benchmark criteria for social marketing. Segmentation enables the intervention to be targeted effectively and to have the most impact possible. There is no such thing as 'targeted at the general population'.

Critically, however, segments must be accessible and practical. So, it must be possible to reach the people in the segment (data, records, addresses). The segments must be real rather than academic. This is particularly the case if segmentation is based on psychological or behavioural characteristics. It is vital to ask 'do people really think/act like this?' Finally the segment must enable an intervention to have the desired results. If the desired result is 150 more quits in a year, targeting the hardest to reach group who are hardened smokers is unlikely to have the desired effect. However if the desired result is to increase the number of smokers contemplating quitting, this could be a suitable segment – but only if they are possible to reach and identifiable.

The scoping report so far can suggest ways that the Evelyn population could potentially be segmented to target a social marketing intervention. These possible segmentations are described below, with justification given and any potential link with a stakeholder or community group. It is of note that the Pepys Community Forum (Lewis Herlitz) and Evelyn Neighbourhood Management Panel can be considered stakeholders for all groups and should be considered a steering committee for any future intervention. This was suggested to the ENMP by Jane Miller on 20th June 2007.

	Potential segmentation	**Justification**	**Possible stakeholder group**	**Opinion**
1	Men aged 35-44.	• 49% of men smoke and 35% women. • 35-44 year olds access local cessation services the most.	None in particular. Community Forum and Neighbourhood Panel may be of use as may the John Evelyn pub and VAL.	This is a good group to target, but without the added segmentation of ethnicity it may be difficult to effectively target the intervention.
2	Asthma sufferers	N1 has the highest asthma hospital admission rate in London and twice the national rate.	• Mornington • Grove • Lockyer's • Waldrum (Batra/Irvine)	Asthma may be a good link into a segment. Asthma sufferers will benefit from quitting and could easily be accessed from GP data if it were permitted.
3	Parents of asthmatic children	As above	• As above • Clyde Street children's centre • Deptford Green School • Evelyn Early Years Centre	Parents will be concerned that their smoking will effect their children and this could be used as the basis for an intervention
4	Smokers with children	Anecdotally there is much concern amongst parents that their smoking will damage their children's health.	• As above	

5	Adults in routine employment	There was much anticipation of the forthcoming smoking ban and an expectation that quit attempts will increase.	• Waldrum • Mornington • Grove • Lockyer's • QUIT • Lewisham Community Development Partnership • John Evelyn pub • VAL	Employed residents of Evelyn tend to work in catering, which traditionally has long hours and poor conditions. There are also numerous people in manual employment which is a hotbed for smoking. These workers will be effected by the ban and offering the right encouragement and messages may improve smoking cessation rates dramatically.
6	Vietnamese men	Many Vietnamese men smoke yet no Vietnamese people saw a smoking cessation advisor in 2006. Smoking is an integral part of Vietnamese culture.	• FORVIL • Deptford Vietnamese Project • Federation of Refugees from Vietnam • REETA	This segment is not low hanging fruit. Vietnamese men clearly do not desire to give up. The behavioural goal may have to be increasing intention to quit rather than increasing quit attempts and rates. The language barrier is significant, also, although Vietnamese community workers such as Alex Hopkins may overcome this.
7	Bangladeshi and Indian men	Again, many Bagladeshi and Indian men smoke but are unwilling to give up	• Lockyer's Pharmacy • Possibly Grove and Mornington • Waldrum • QUIT • REETA	This segment again is not low hanging fruit and considerable work would have to be done to gain the trust of the group. There are no specific stakeholder groups identified who could support an intervention targeting this group.
8	Somali men	Many Somali men smoke.	• Lockyer's Pharmacy • Possibly Grove and Mornington • Waldrum • QUIT • The Somali Project • SEDEC • REETA	Anecdotally there are far more Somali women than men in Evelyn. Many arrive as asylum seekers. The previous project targeting this group had little success but QUIT have written a full report and could be useful stakeholders if this was considered a target group. Several community workers have commented that smoking is not a considerable problem in the Somali community, although chewing tobacco is.

9	Established refugees	New refugees are more concerned with learning English, finding accommodation and getting to grips with benefits and welfare systems. Learning that England has a culture of quitting smoking may well be too much to handle for new refugees. Establish refugees, however, are involved with seeking employment and becoming valued members of the community. They may be susceptible to an intervention as part of this process	• LCDP • Building Healthy Communities • Deptford Green School • Clyde Street Childrens Centre • REETA • Community Drug Education Project	This group may be too large to target effectively. However, refugees who are accessing services to better integrate into the community (childcare, employment, training, health advice) may also be 'contemplators' for improving their own health and believe they can make a positive change to their smoking status. Cultural barriers between groups may prevent an intervention having real impact, however.
10	Muslims	Muslims celebrate Ramadan, which involves fasting from dawn until dusk for a month. Interventions have been run in the past to encourage smoking cessation to become part of the Ramadan ritual of fasting	• DCF • LNP • Deptford Green School	There is a danger that overcompensation occurs during Ramadan, ie. smokers binging after nightfall. However, this seems like an ideal time to target this group. The Muslim population of Evelyn is large, with Asian, Somali and some Eastern European members.
11	Pregnant women	No pregnant women from Evelyn accessed any smoking cessation service in 2006.	• Deptford Green School • Clyde Street Early Years Centre • Grove • Mornington • Lockyer's • Waldrum • Surestart/Evelyn Early Years Centre • VAL	There is considerable evidence that interventions targeted specifically at pregnant women can have significant success.
12	Young people	There are a disproportionately high number of young people in Evelyn.	• Deptford Green School • Riverside Youth Club • Milbrook Youth Club • Police initiatives	A prevention intervention may be viable.

12.1 Conclusion

The 6 segments considered to be the most accessible and practical are:

- Parents of asthmatic children
- Parents
- Vietnamese men
- Muslims
- Pregnant women

- Young people

It is believed that

- Data could be available for these segments:

Segment	Data source
Parents with asthmatic children	Deptford Green School Clyde Street Early Years Centre GPs
Parents	As above
Vietnamese men	Electoral roll FORVIL Deptford Vietnamese Project Federation of Refugees from Vietnam REETA
Muslims	Electoral roll Local mosque (this may be more difficult)
Pregnant women	GPs
Young people	GPs Schools Riverside Youth Club Police

- Stakeholder groups may be available to support interventions targeting these groups
- These segments (with the exception of Vietnamese men) are likely to produce significant results in terms of quit attempts and successes if an intervention is properly targeted. [Vietnamese men would be more difficult, but as smoking is so prevalent in the group, any increase in quit attempts using services available would be an improvement.]
- It would be possible to track the results of an intervention using stakeholders and current services
- There is a real need within the segments for a change in smoking behaviour.

A strong personal recommendation would be to focus on

- prevention and cessation with young people
- cessation with pregnant women and
- cessation with parents

These interventions could be bolstered with considerable work advertising the ban, particularly amongst the Vietnamese community. The ‘social norm’ approach could be taken, to present the idea that the norm has become a non-smoking British culture and therefore to smoke is to no longer fit in. This message has not reached the Vietnamese community in Evelyn.

13.0 Recommendations for further research

It is clear from this report and from evidence in the social marketing field that in order to effectively target the chosen segment or segments, considerable insight must first be gained. This insight will enable the intervention to be developed which specifically links into the requirements, fears and desires of the target group. Crucially, this insight will enable the intervention to offer an exchange to the target group which is desirable enough for them to be persuaded to access a local service in order to attempt to give up smoking. As was previously identified, at this stage it is not possible to identify the factors which will lead to this successful exchange for the identified segments, so further research is recommended.

However, before research recommendations are made, a further look at research into each segment has been undertaken to gain a picture of what is known before research designs are drawn up:

Men aged 35-44

A review of more than 100 studies on smoking cessation found that

- Women appear to suffer greater risks of smoking-related diseases than men and tend to have less success than men when they try to quit smoking.
- Men tended to benefit more from nicotine replacement therapy. One study by Joel Killen, Ph.D., of Stanford University found that using nicotine gum resulted in abstinence from smoking twice as often in men as did using a placebo. For women, however, the nicotine gum didn't help them to abstain from smoking. Yet another study found similar results with the nicotine patch, where 17 percent of women but 24 percent of men were able to abstain from smoking with the treatment.[108]

Adults in routine employment

Thirteen existing smoking cessation groups in a low-income community were interviewed over six weeks. Findings suggested that highly structured standardized 6-8 week programmes in smoking cessation are insufficient to meet the needs of many smokers. Instead a story-based intervention was used to both locate the process of change within people's daily lives as well as to enable people to engage in a supportive process with others at different stages of change. The intention to change is perceived by many smokers to be unstable and requires opportunities for longer-term support. Flexibility in their attendance and ongoing support to both make the decision to stop and stay stopped is clearly valued by the participants. Many find the insights of those at the different stages very valuable in their own attempts to quit. Current practices of excluding smokers who are still unsure of their own motivation are challenged. The hypotheses generated by the work suggest that flexible services that offer support to a range of smokers are beneficial and valued. In addition, programmes that are tailored to the individual's context and culture, as well as the individual's personal life situation, through the medium of the story, are valued and acceptable to the participants.[109]

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[108] Smoking Cessation Harder for Women than Men. *Psychiatric News* June 15, 2001 Volume 36 Number 12

[109] Ritchie, D; Schulz, S and Bryce, A (May 2007). One size fits all? A process evaluation – the turn of the 'story' in smoking cessation. Public Health.121(5):341-8.

Focus groups were conducted with 39 smokers aged 21-75 from the most socio-economically deprived areas of Nottingham UK who had made an unsuccessful attempt to quit within the last year without using smoking cessation services, to identify specific barriers or motivators to gaining access to these services. Barriers to use of existing services related to fear of being judged, fear of failure, a perceived lack of knowledge about existing services, a perception that available interventions--particularly Nicotine Replacement Therapy--are expensive and ineffective, and negative media publicity about bupropion. Participants expressed a preference for a personalized, non-judgemental approach combining counselling with affordable, accessible and effective pharmacological therapies; convenient and flexible timing of service delivery, and the possibility of subsidized complementary therapies. Smokers from these deprived areas generally had low awareness of the services available to help them, and misconceptions about their availability and effectiveness. A more personalized approach to promoting services that are non-judgemental, and with free pharmacotherapy and flexible support may encourage more deprived smokers to quit smoking.[110]

Vietnamese men

This research aimed to increase our understanding of minority smokers' experiences and beliefs about guideline-recommended smoking cessation treatments. 16 focus groups among current and former smokers from four ethnic minority communities in Minneapolis/St. Paul were undertaken (in 2005). Focus groups were conducted separately for American Indians, Vietnamese, Hmong and African Americans. Participants reported little experience with counseling and views on seeking help from physicians were mixed. African American and American Indian participants expressed feelings of mistrust and negative experiences with doctors. Hmong and Vietnamese smokers viewed doctors positively but did not regard them as an important resource to help with quitting, and especially for Vietnamese, the cultural value of mental control and self-determination was seen as most important to quit smoking. Across all the groups, pharmacotherapy was rarely utilized and participants had low knowledge and poor understanding of the benefits of pharmacotherapy. Personal beliefs, views toward doctors, and lack of knowledge are important determinants of the use of tobacco treatments among ethnic minority smokers. In order to increase minority smokers' utilization of evidence-based tobacco cessation treatments, effective strategies are needed to deliver accurate information about treatment from trusted sources.

Bangladeshi and Indian men

This qualitative research research explored attitudes to quitting smoking and experience of smoking cessation among Bangladeshi and Pakistani ethnic minority communities in Newcastle. Motivation to quit was high but most attempts had failed. "Willpower" was the most common approach to quitting. For some, the holy month of Ramadan was used as an incentive, however few had been successful in quitting. Perceived barriers to success included being tempted by others, everyday stresses, and withdrawal symptoms. Few participants had sought advice from health services, or received cessation aids, such as nicotine replacement therapy (NRT) or buproprion. Family doctors were not viewed as accessible sources of advice on

[110] Roddy, E; Antoniak, M; Britton, J; Molyneux, A and Lewis, S (July 2007). Barriers and motivators to gaining access to smoking cessation services amongst deprived smokers – a qualitative study. BMC Health Serv Res. 6;6:147.

quitting. Health professionals and community members identified common barriers to accessing effective smoking cessation, including: language, religion and culture; negative attitudes to services; and lack of time and resources for professionals to develop necessary skills. High levels of motivation do not seem to be matched by effective interventions or successful attempts to quit smoking among Bangladeshi and Pakistani adults in the UK. There is a need to adapt and test effective smoking cessation interventions to make them culturally acceptable to ethnic minority communities. UK tobacco control policies need to give special attention to the needs of ethnic minority groups.[111]

(Minority ethnic groups, older people and mental health and wellbeing)
This research found that

- Most people started smoking out of curiosity or due to social pressures. Early experiences of tobacco use were shaped by the social and historic circumstances in which the participants were living. In particular, older adults and first generation ethnic minorities started to smoke in a cultural climate where smoking was more socially acceptable and there was less incentive to quit.
- Participants associated smoking with their daily routine, and with stress relief and relaxation. Few people acknowledged that they might be addicted to tobacco. The mental health groups focused more on smoking as a coping mechanism to deal with difficulties, while the minority ethnic groups spoke more of smoking as a way to relax and socialise.
- There was a general awareness that smoking was bad for health, but knowledge and acceptance of the risks varied greatly. This depended on personal experience of tobacco-related illness, information from medical or smoking cessation professionals and personal or cultural beliefs about health.
- Experiences of quitting were a normal part of the participants' tobacco use history. Health was the primary motivation to quit. Family, the social acceptability of smoking, finances and appearance were popular secondary motivations. Most people had tried to stop smoking at some point in their lives, often for extended periods of time or on multiple occasions. Relapse was common and was usually associated with stressful events, habitual triggers and side-effects of quitting. The minority ethnic participants had fewer experiences of successful quitting.
- Approaches to quitting varied. A number of recent quitters had sought support from smoking cessation services or had used pharmaceutical cessation aids (NRT or Zyban), while others preferred to go 'cold turkey'. There was widespread belief that determination and will-power were essential, and that the decision to stop has to come from within. Older men and minority ethnic men were most vocal about quitting on their own.
- Awareness of smoking cessation services was low amongst participants who had not already received specialist support to quit. However, there was a general interest in smoking cessation services when these were described to participants. People who had used smoking cessation services spoke favourably about the professional support, the group support and the education value of the sessions they attended.

[111] White, M; Bush, J; Kai, J; Bhopal, R and Rankin, J (May 2006) Quitting smoking and experience of smoking cessation interventions among UK Bangladeshi and Pakistani adults: the views of community members and health professionals. Journal of Epidemiology and Health, 60(5):405-11

- Attitudes and experiences of NRT and Zyban varied. Awareness of the availability of patches and gum was high, but negative attitudes about the efficacy or safety of smoking cessation products were common. The older males generally spoke less favourably about pharmaceutical cessation aids than the females.
- Mass media campaigns and other health promotion resources (e.g. leaflets) were valued for drawing attention to issues, but it was recognised that there are limits in their effectiveness and reach. It was felt that the media could be used to better publicise support that is available to help people quit.
- Some people feel pressurised by changing social attitudes towards smoking, including the forthcoming legislation on smoking in public places, and were concerned about potentially negative social and personal impacts. There was also some confusion about the scope of the legislation and the motivations for this. Participants in the mental health groups were most vocal on this matter. Others felt that the legislation sent a clear message about the risks of tobacco smoke and would be beneficial to people who were trying to stop.[112]

Pregnant women

1. Qualitative research was conducted in deprived areas of South Yorkshire, with levels of smoking-related ill health higher than the national average. The study participants revealed a belief system resulting in a self-fulfilling prophecy of relapse or failure to quit. Other barriers were the influence of family and friends, how women interpreted facts relating to smoking risks and the nature of smoking cessation service delivery.

2. This research found that among pregnant women, the most frequently endorsed barriers were 'Being afraid of disappointing myself if I failed' (54%) and not tending to seek help for this sort of thing (41%). The most frequently endorsed benefits were advice about cigarette cravings (74%) and praise and encouragement with quitting (71%). A greater interest in receiving help with quitting from a counselor was significantly associated with being older, lower income, husband/partner advising cessation and less confidence in quitting. Pregnant smokers perceive many benefits of smoking cessation courses. However, these women also perceive many barriers to attendance and studies are needed to evaluate interventions for overcoming such barriers. Smoking cessation services need to address the perceived barriers to attending stop smoking courses during pregnancy, to publicise the benefits of these courses and to target women who feel that they cannot quit without this type of support.

Young people

1. Research was undertaken in three youth-clubs and two secondary schools in south-east Wales with 25 male and female 13-18-year-olds, mainly daily smokers. Interviewees did not assume immediately that a smoking cessation service is something that will be available to them, and therefore they initially encountered difficulties in identifying attributes of such support. Their main preference was for support from friends and family, access to nicotine replacement therapy and non-school-based, flexible support and guidance. The results re-emphasize that developing more adolescent-appropriate support requires a reconceptualization of

[112] http://www.ashscotland.org.uk/ash/files/service%20users%20report%20.pdf

existing interventions, with service users situated at the core of intervention design. The study highlights a number of service development points for intervention planners including: rethinking the timing and location of provision; placing more emphasis on the selection of facilitators; harnessing support from friends and family; and rooting these developments in broader tobacco control strategies.[113]

2. Research shows that parents can be a key influence on their children's decision not to smoke. Research has also shown that parents who communicate regularly with their children in general, and who talk with them about not smoking in particular, decrease the likelihood that their children will smoke.[114]

There appear to be considerable research gaps in the areas of attitudes and beliefs of

- Somali adults
- Parents who smoke (with children with asthma or without)
- Asthma sufferers
- Established refugees
- Muslims

In this section, a draft research plan and budget are outlined for each of the recommended segments. For each segment, key research questions will be listed along with recommended research methodology. In all cases a key priority would be finding a researcher who will be accepted and trusted by the target group. This way the research will be more likely to be probing, generating rich and meaningful answers. A budget and timescale guide are also given. It is important to stress that it is not recommended that each of these segments is tackled at the same time. Rather, one or two should be focused on.

13.1 Parents of asthmatic children

13.1.1 Key research questions

f. What are the key emotions surrounding the issue of smoking around the asthmatic child?
g. Is there a knowledge gap regarding the link between smoking and asthma?
h. What are the key barriers to cessation or attempted cessation?
i. What are the parent's opinions and feelings about (as well as experiences of) current cessation services?
j. What form of service would be the most supportive for this group?

13.1.2 Recommended research methodology

A qualitative research methodology is recommended initially, to explore fully the emotional aspects of smoking with asthmatic children in order to establish the emotional pressures faced by parents who smoke with asthmatic children. A

[113] Macdonald, S; Rothwell, H and Moore, L (July 2007). Getting in right: designing adolescent-centred smoking cessation services. Addiction. 2007 Jul;102(7):1147-

[114] Powell, L., & Chaloupka, F. 2005. "Parents, public policy, and youth smoking" Journal of Policy Analysis and Management, Vol. 24, No. 1 93-112.

Jackson, C., Henriksen, L. 1997. "Do as I say: parent smoking, antismoking socialization, and smoking onset among children." Addictive Behaviors Vol.22, No.1, pp 107-114.

qualitative phase is also recommended to explore barriers to cessation. This is likely to take the form of one to one interviews and focus groups.

A second, quantitative phase may be required to establish patterns in the needs and opinions of the parents so that cessation services can be developed or changed in line with a representative picture of their needs.

13.2 Parents

13.2.1 Key research questions

f. What are the key emotions surrounding the issue of smoking around children?
g. Is there a knowledge gap regarding the danger of passive smoking for children?
h. What are the key barriers to cessation or attempted cessation?
i. What are the parent's opinions and feelings about (as well as experiences of) current cessation services?
j. What form of service would be the most supportive for this group?

13.2.2 Recommended research methodology

A qualitative research methodology is recommended initially, to explore fully the emotional aspects of smoking with children in order to establish the emotional pressures faced by parents who smoke. A qualitative phase is also recommended to explore barriers to cessation. This is likely to take the form of one to one interviews and focus groups.

A second, quantitative phase may be required to establish patterns in the needs and opinions of the parents so that cessation services can be developed or changed in line with a representative picture of their needs.

13.3 Vietnamese men

13.3.1 Key research questions

f. What are the cultural connotations with smoking?
g. What is the relationship between smoking and masculinity in Vietnamese culture?
h. What are the key barriers to smoking cessation?
i. How would smoking cessation advice best be delivered?
j. What are the experiences and opinions of current services?

13.3.2 Recommended research methodology

A qualitative research methodology is recommended to explore the cultural and gender connotations of smoking for Vietnamese men. A Vietnamese speaker is recommended for this research. Key barriers and opinions of local services can be explored qualitatively. A postal survey for quantitative analysis is not recommended based on previous focus groups with Indo-Chinese Lewisham residents, who prefer face to face communication than by survey. If a survey were decided upon, it should be in Vietnamese for best results.

13.4 Muslims

13.4.1 Key research questions

f. What are the religious and cultural connotations with smoking?

g. What are the feelings towards long-term abstinence in terms of religious belief?
h. What are the possible implications of the Ramadan fast on smoking cessation?
i. What are the opinions and experiences of current cessation services?
j. What would the ideal support be for quitters during Ramadan?

13.4.2 Recommended research methodology

A qualitative research methodology is recommended to explore the cultural and religious connotations of smoking for Muslim people and to focus specifically on the possible positive repercussions of Ramadan on smoking cessation attempts amongst Muslims in Evelyn. Interpretation may be required. Key barriers and opinions may be gained from the qualitative work as well.

A second, quantitative phase may be required to establish patterns in the needs and opinions of the Muslims so that cessation services can be developed or changed in line with a representative picture of their needs.

13.5 Pregnant women

13.5.1 Key research questions

e. What are the key emotions regarding smoking whilst pregnant?
f. What are the key barriers to cessation for pregnant women smokers in Evelyn?
g. What are pregnant women's opinions and experiences of cessation services available
h. What would the ideal support be for cessation?

13.5.2 Recommended research methodology

Qualitative research is recommended (interviews and focus groups) to explore emotional issues, barriers to cessation and opinions of current services and recommendations for ideal services and support. Further quantitative work may be required to test findings with a broader group of pregnant women, recent mothers and particularly ex- and current smokers within these groups. This may be done using an incentivised, pre-tested postal survey.

13.6 Young people

13.6.1 Key research questions

f. What is life like for young people in Evelyn?
g. What are the pressures to smoke and barriers to cessation?
h. What is the youth culture surrounding smoking?
i. What are the young people's opinions of current cessation services?
j. What kind of service would most appeal?

13.6.2 Recommended research methodology

Again, qualitative work is recommended to get to grips with the particular issues surrounding smoking and cessation for young people. It is unlikely a quantitative survey would be successful. It is vital that the individual carrying out the qualitative work is well respected and trusted within the youth subculture.

13.7 Budget guide

The figures within this budget guide may be applied to any of the segments chosen.

Activity	Notes	Costs
Writing research design and module guide	NSMC Associate time x 1 day	£200 - £500
Recruitment	Lewisham PCT will be asked to recruit participants but associate will arrange the meetings 1 days of phone calls and arranging (associate time)	£200 - £500
Interviewing	An average schedule would be 20 interviews and 2 focus groups. This is 5 days of interviews plus a day for focus groups.	£1200 - £3000
£10 incentive for participants	32 participants	£320
Expenses	6 nights in a hotel Travel	£525 £100
Transcribing	£15 per hour (3hrs for a 1hr interview)	£1080
Analysing and writing up	10 days of associate time	£2000 - £5000
Total		£5425 - £10,525

Costs for the quantitative stage will vary depending on the required sample size (which in turn depends on the desired level of statistical significance). However, the following costs must be taken into consideration when budgeting for research:

- questionnaire development
- pilot testing
- printing
- posting
- second wave printing and posting
- incentive
- data input
- analysis
- report writing

13.8 Timescale guide

Fulfilling the quota is the most time consuming activity for the PCT. The qualitative research, transcription, analysis and report writing can all be done inside 6 weeks. The quantitative stage can take much longer due to waiting for questionnaires to be returned, sending a second wave questionnaires and data inputting.

13.9 Ethics

13.9.1 Ethics in research

In order to conduct the research, the issue of ethics must be carefully considered. The ethics committee may need to be consulted in the following cases:

- when information is required about an individual's health status and when an individual's health status is discussed
- when information is required from a GP or other health professional
- when people are being consulted about an illegal behaviour (such as underage smoking)

13.9.2 Ethics in social marketing

In addition, ethics in social marketing must be carefully considered. The following 2 checklists can be employed when the social marketing intervention is developed:

An ethical checklist for social marketing (Donovan and Henley, 2004)

a. Ensure that the intervention will not cause physical or psychological harm
b. Does the intervention give assistance where it is needed?
c. Does the intervention allow those who need help the freedom to exercise their entitlements?
d. Are all parties treated equally and fairly?
e. Will the choices made produce the greatest good for the greatest number of people?
f. Is the autonomy of the target audience recognised

A code of ethics for social marketing (Rothschild, 2001)

a. Do more good than harm
b. Favour free choice
c. Evaluate marketing within a broad context of behaviour management (giving consideration to alternatives of education and law)
d. Select tactics that are effective and efficient
e. Select marketing tactics that fit marketing philosophy (that is meeting the needs of consumers rather than the self-interest of the organisation)
f. Evaluate the ethicality of a policy before agreeing to develop a strategy

14.0 Next steps

The following next steps should be made towards developing the social marketing intervention:

1. Discussion with Lewisham PCT to finalise target group, behavioural goals and timescales and to identify key stakeholders.
2. Discussion with key stakeholders to define their level of involvement and interest
3. Dissemination of scoping report findings to key stakeholders and broader interested group
4. Discussion of primary research strategy and research questions with key stakeholders
5. Primary research conducted and analysed
6. Dissemination of primary research to key stakeholders and broader interested group
7. Brainstorming to generate initial ideas for intervention with a focus on the possible exchange and theoretical base
8. Generate broad plan for intervention, including evaluation methodology
9. Make internal changes where required, in line with stakeholders
10. Invite external agencies to pitch for marketing communications work
11. Implementation
12. Evaluation
13. Follow up